Conflict in an acute general hospital

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C O N F L I C T

I N

A N A C U T E

G E N E R A L H O S P I T A L

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TO MY PARENTS

SUMMARY

The focus of this qualitative study is the phenomenon of conflict in the Bendigo and Northern District Base Hospital (BBH), Victoria, Australia. The research is exploratory, analytical and interpretative adopting a case study approach. Its aim is to gain greater empirical knowledge about the complexity and functioning of a hospital and a deeper insight into the realities of conflict and how people go about addressing it.

Conflict is seen as an inner struggle or as a clash between various parties over values, ideas or orientation to the task. The research shows quite clearly that conflict in this Hospital is endemic and its magnitude is tied to the complexity of the institution.

I devised an heuristic framework comprising contextual factors and various immediate antecedents which are interrelated and lead to different levels of conflict within the Hospital.

The environmental context in which the Hospital exists plays a important role in its operation and management. It is the power of the medical staff which enables them to assume a position of primary importance in the decision-making process of the institution. This complicates the role of the key people in the mangerial system and makes the problems of control rather complex.

The study analyses the flow of three types of patients through the system, and their various encounters. At the same time it focuses on the various operational units through which these patients journey, namely the wards and the operating theatre suite.

There are four salient major determinants of conflict identified. Each instance of conflict carries several determinants at the same time. The first determinant lies in the

lack of coherence in the management of activities. The second lies in the dilemma of balancing the requirements of the treatment of patients with those of maintaining the state of the hospital itself. The third arises from differences in orientation toward the handling of the therapeutic process. The fourth arises from the overlap in the function of specialized units in the treatment of patients.

The people in the Hospital find themselves caught up in the structure. The nearest they get to managing conflict is to force it aside in their concern for the patient.

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In particular, I would like to thank the previous CEO of the Hospital, Mr N. Phillips who gave the permission to enter this institution for the purpose of research. Special thanks are also due to the Charge Nurse of Ward 1, Mrs W. Wilkinson who granted me the first interview and then introduced me to many of her colleagues.

I also owe a vast debt of gratitude to my supervisor, Mr. G. Hutton for his faith and enormous support and encouragement as well as his constant inspiration and valuable criticism. My appreciation also to Professor J. Morris and Dr. J. Marshall for their considerate criticism.

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A research project of this nature is anything but an individual effort. In addition, the personal, social and financial deprivation is quite high. Nevertheless, this cost has been more than compensated for by the enlightenment and the pleasure I have derived from researching and writing up the thesis and for whose final product I accept full responsibility.

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INTRODUCTION

Hospitals continue to be one of the most complex and dynamic organizations in modern society. This complexity results from a number of attributes such as their multiple objectives, diversity of personnel, multiple lines of authority, continuous operation, and problems of life and death. Moreover, advances in technology, greater consumer demand, and growing economic and political pressures are increasing the problems facing hospital management.

In achieving the major objective of patient care and treatment, hospitals operate through a highly specialized system of multiple activities and interactions of various professional, semi-professional and non-professional members, who engage in numerous and varied interdependent relationships. Consequently, hospitals (like many other large-scale organizations) are full of antagonisms, tensions and conflict. In fact, the closer the interdependencies and the greater the heterogeneity, the more prone to conflict is the organization.

I have had a long term connection with the Bendigo and Northern District Base Hospital (BBH) dating back to the 1970's during which time I was involved in various teaching programs to the nursing staff in that hospital and became aware of a great deal of conflict within that institution. This attachment set the scene for using this hospital for my research. The Chief Executive Officer (CEO) expressed some interest in finding out about the nature and the management of intra-organizational conflict.

Scanning the literature I found that little empirically based research had been carried out on conflict management in organizations, and even fewer studies have examined the subject in health care institutions. Organizational conflict is a familiar

characteristic, especially ubiquitous within larger hospitals. It occurs continually, arises for a variety of reasons, appears in a variety of forms, and affects the hospital both favourably and unfavourably.

I could just see myself in the role of a quasi-physician by taking its pulse, measuring its temperature, analyzing its sneezes, counting its hiccups and inspecting its blemishes. I thought it might lead to a healthier "patient" by analyzing the results and thereby obtaining a sounder understanding and conceptualization of the nature of that particular social system and the study of conflict processes within it.

I felt excited and important that I would eventually be the one who could find a solution to the management of conflict within this particular institution. This magic formula could then be used in other hospitals as well. Unfortunately this was not to be. As the reader will eventually discover I was merely setting up false hopes in being able to help to solve the conflicts that emerged. That aim and its ultimate failure are all part of the data. The research begins with my entry into this organization and ends with no real solution on hand as to how effectively to manage conflict within it. Nevertheless I developed a greater understanding of why that should be.

My research study had the following objectives:

(a) To understand the nature and extent of interpersonal and intergroup conflict.
(b) To identify the various factors which lead to interpersonal and intergroup conflict.
(c) To describe the effects of conflict on organizational life and the reactions to it.
(d) To show empirically how the particular kinds of conflict are being managed.

In order to achieve these objectives it was now a question of taking appropriate action and making some important choices and selections. I had to make the most productive use of my time. This meant finding opportunities for engagements which satisfied my own curiosities, gave me access, and exemplified a great deal of conflict.

As it was important for me to work within the sanction that I had from time to time, I decided to start where I could, and make further choices as the learning progressed. Consequently, I started with an existing contact that I had with the Director of Nursing which then led to an introduction to the male surgical ward. This also gave me an opportunity and a practical way to start to build relations and open the way to further work.

Because I was unable to look at the whole system in operation, I tried to find those sub-systems which would illuminate those different types of conflict which I knew existed arising from professional differencess, task priorities and so on. Apart from the male surgical ward in which I made the preliminary study due to my initial contact with the Charge Nurse, I chose the children's ward and the maternity wing because they offered a good and interesting contrast. The children's ward is a general medical ward, and children are interesting as patients because the focus is also on their relations with their parents. The maternity ward is interesting since expectant mothers with normal birth are not really patients in the usual sense of the word. My personal reasons which attracted me to the children's ward and the maternity wing are my love of children and having witnessed the birth of my own two sons in this hospital.

Apart from the three types of patients, I chose the Operating Theatre Suite because it seemed to be the one place where most of the rumblings about conflict occured. It looked like offering a rich fertile field for researching conflict.

As an alternative perspective I was also interested to trace the journey through the Hospital of three individual patients, namely a male surgical case, a young child, and an expectant mother. It was clear that some conflicts were occuring between different departments. Since patients tend to move through several of these departments this mode of study should reveal conflicts at the boundaries. It is the story of a journey describing each patient's experiences in terms of a sequence of tasks, crossing boundaries, and a number of encounters with people and things.

PART I

APPROACHES

CHAPTER 1
ORIGINS AND DESIGN

ORIGIN OF THE PROJECT

A few years after joining the Bendigo College of Advanced Education, I was approached by the Bendigo School of Nursing at Lister House during the middle of the 1970's with a suggestion that I teach basic administrative concepts to senior nursing staff from various hospitals around the district. In discussion with these nurses I was able to gain some insight into the unique and complex world of hospital life and a desire for further knowledge in that direction. Moreover, if one is to teach practical administrative skills to a senior nurse it is important, if not vital, to have a sound understanding of the context or social system in which that incumbent enacts his or her role.

The connection with the school brought me into contact with the Director of Nursing at the Bendigo Base Hospital, who later, through the head of the Nursing Training Division, arranged some further seminars for me. This was the first of a number of valuable encounters which later opened several doors in the Nursing Division itself.

It was also during this time that I joined the Bendigo Branch of the Australian Institute of Management, having been a member of the institue for quite some time prior to coming to Bendigo. At the branch I met the Chief Executive Officer of the Hospital who happened to be the president at the time. It was through his approval and recommendation (for which I am forever grateful) that I was given the right of access to the Hospital and the permission to conduct my exploratory research.

Both the Chief Executive Officer and the Director of Nursing (who have retired in the meantime), initially became my "Guardian Angels" and made sure that the settings in which I worked were protected. The endeavour to earn the right to cover and sanction and support is most important (Hutton 1979).

Many organizations do not normally welcome observers which means that access to positions from which study may be undertaken is very difficult to obtain. It seems that hospitals, especially, are rather relucant to open their doors because of the nature of their task, placing more emphasis on the value of privacy in certain spheres of personal and institutional behaviour (Weisbord et al., 1978; Rubin et al., 1972). As far as I can gather I am the first researcher to have been allowed into this hospital for such a sustained and in-depth study.

During the year 1977, I began to seriously consider in taking up further studies in the organization and management field. On the advice from a colleague from the University of Melbourne I wrote to the University of Bath with the idea of undertaking a Masters Degree in the School of Management. After outlining my interests I was eventually referred to Geoffrey Hutton who agreed to become my supervisor for a MSc in Organization Analyis and Development which meant an attachment at the University from October 1979 till the end of September 1980.

Apart from being able to explore the delights and beauty of Bath and its surroundings, academically, this rite de passage resulted in two significant learning experiences for me. Firstly, under Geoffrey's guidance and the study group that I attended on a regular basis as well as the presentation of the two major symposiums, allowed me to greatly enrich my understanding of organizational analysis and development.

Secondly, the opportunity to conduct an exploratory study of Clark's Shoe Factory in Bath, focussing on the role of the Production Superintendent, was a challenging and exciting introduction to field research. Although I had a co-operative gatekeeper who initiated the project, I was, nevertheless, left very much to my own devices and initiative. I learnt to utilize various diverse methods such as observation, participant observation, unstructured interviews and the analysis of documentary material, all of which had to be applied to the specific social setting. I didn't really have to sell myself to the people I observed and interviewed, but found that one becomes accepted as a participant observer because of people's perception of you, the impressions that you make, and the manner in which you conduct yourself. That is, what really seems to matter is the subject's opinions of you as a whole person coupled with the research fulfilling some of their needs.

The experience at Clark's, and the fact that I completed my degree, gave me the confidence in conducting further social research. People tell me that I have an honest and trustworthy face and that they recognize my genuine interest in trying to understand their situation and to help them where I can. This provides me with the necessary acceptance and co-operation from individuals and groups I wish to observe and interview. If people trust you and feel comfortable in your presence, they enjoy being studied and find the attention given to them flattering. I have acquired quite a taste for field research and find genuine satisfaction in immersing myself into a new social setting or culture which is foreign to me.

There were several reasons as to why I chose the topic of conflict in a hospital setting for my thesis. After my return to Australia towards the end of 1980, I continued with my job as Course Co-ordinator in Managerial Studies with renewed vigour and enthusiasm. It was during this time when the demand for health administration courses was on the increase and more and more

people in the health field were inquiring as to when the College would introduce such a course. I also found that a greater proportion of my time was taken up with continued lecturing to nurses as well as conducting seminars for health service officials outside of the college. Consequently, my curiosity about hospitals as a focus of organizational analysis intensified, coupled with the desire to carry my studies further.

I wanted to gain new and more relevant knowledge about the functioning and complexity of a hospital in order to improve the education and training for hospital personnel. This need for a better understanding was reinforced midway through the study when I became a board member and realized the lack of understanding about this institution by some of my colleagues on that board. I found it useful in being able to analyze more clearly certain problems facing the Hospital and the analysis of different processes within it. Finally,I wanted to develop a newer and fresher approach to the understanding of conflict which would be relevant and practical in my own personal quest in dealing with this phenomenon as well as being able to help others in similar situations.

With Geoffrey Hutton's encouragement I enrolled to read for a Ph.D. with my focus of interest on conflict in the BBH.

STARTING RESEARCH AND GAINING ACCESS

As I mentioned previously, my research interest in the Hospital was kindled whilst conducting seminars on ward administration to charge nurses from the various local hospitals. So, I decided to begin my field research at just such a setting, namely the ward. I started to read several publications on the role of charge nurses and ward management in general. This literature review enabled me to gain a basic understanding of ward structure and functioning. I became very interested to see how a ward actually functioned in reality.

I went to see the Director of Nursing, whom I already knew through my teaching of her nursing staff, to discuss the possibility of being able to actually see a ward at work. She agreed and felt it was an excellent idea that I should do so because this would provide a more practical basis for my teaching. Then she suggested that I spend some time in the male surgical ward. She had a great deal of praise for the Charge Nurse there and felt that I could learn a lot from her.

As I had no particular ward in mind at that stage, her suggestion was quite acceptable to me because not only was I able to gain entry, but it also gave the chance of finding a good informant in the anthropological sense of the word. I was introduced to the charge nurse of the male surgical patient-care unit as "a lecturer from the Bendigo College who is teaching ward administration and therefore wants to learn about life on the ward". This introduction was then passed on during the course of my stay by the sister to medical staff, nurses, and other ward personnel, many of who became my "gatekeepers". My rapport with the charge nurse was excellent right from the start, and she became invaluable not only in providing information about how the ward functioned and the interpersonal relations in the ward, but also by introducing me to the charge nurses of other wards.

During the latter half of 1983 I was able to establish contacts and research relations with many other participants in the Hospital. At each introduction it was made clear, either by myself or others, as to the reason of my being there. Everyone concerned knew who I was and what I was doing, and gave me permission to gain access. It was a slow build up in getting to know people, earning my right to be there, and winning their trust and earning their sanction.

After several months of working and engagement in the surgical unit, I became acquainted with ward routine and organization, closely observing the social interactions among ward personnel, patients and visitors. I accompanied doctors on ward rounds, watched the traffic in the corridors, sat in the charge sisters office (with a view to the whole nursing unit), and mingled with some of the nursing staff in the canteen during coffee breaks and lunch. At all times I observed, asked questions, and made sure I didn't disrupt work routines (especially with regard to the medical staff, an aspect which I will elaborate on later). Everyone is busy and the task is often critical; so I stayed out of their way until members could afford time to confer with me. Often I took notes during my observation but at other times an hour or so elapsed before I returned to my desk, reflected on what I had seen and heard, and recorded the event while it was still fresh in my mind.

One of the biggest constraints in my research was the time factor. Because I was working at the college I could only spend so much time at the Hospital, which usually involved half a day or sometimes a full day a week in the field. This often meant that in the evenings I would review and order the notes made during the day. As the months passed I was able to spend more time in the hospital - long enough, I felt, to be able to have some understanding of what was going on.

It was during this time of preliminary research that I also began to search the literature on hospital organization and conflict. Although I had a fairly good knowledge of organizational literature, I had not viewed it from this perspective, and needed to revisit. There was also the literature on hospitals and on conlfict. I put together the results of my reading, and of my experience in the hospital up to that time, in models or frameworks which helped me to make sense and to guide my later field. These frameworks are discussed in Chapters 2 and 3. Their form changed as the work and the writing proceeded; so they are not presented in exactly their original form.

During 1985 and 1986 I expanded my preliminary research into other areas and sub-cultures of the hospital, such as spending time in the children's ward, the obstetric units and the Operating Theatre Suite. In addition, I interviewed personnel (at various levels) from the medical staff, nursing staff, and paramedical staff as well as people from administration, such as general engineering, food services and domestic services. Moreover, I attended meetings and seminars that I could gain admission to, and participated in a few social events. Whenever practical or relevant, I noted the way in which tasks were carried out and organized, the type of technology in use, the characteristics and personality of the members, and the physical setting in which people found themselves. I also focused on the pattern of events; the way people behaved towards each other; the social rhythm; and the crises, tensions, and anxieties that occured in that small society. Above all, it was interesting to observe what signs of power and conflict processes were in evidence in this unique cultural setting.

During the year 1986, the Hospital experienced significant changes caused by both internal and external events. Because organizations are open systems operating in dynamic environments with ongoing throughputs and adaptation, change becomes inevitable. Blau and Scott (1966) point out that there is

usually a relation of mutual dependence between conflict and change in organizations; change often precipitates conflict, and conflict may lead to better organizational performance or work.

The resistance which is often offered to the introduction of new methods of doing work must be seen in the context of the social situation and the perceptions of the individuals within it. A change will be resisted if it threatens valued steady states and threatens to increase unintelligibility, persecution and separation (Hutton 1972); it is a defence against these undesirable outcomes.

Internally, the Hospital saw the retirement of several of its long-serving key personnel, namely the Chief Executive Officer, the Director of Nursing and Deputy Director of Nursing, along with the night nurse in charge and the supervisor of the operating theatre.

The Deputy Chief Executive Officer took over the reigns of the top administrative job. All the other senior positions, except the night nurse in charge, were filled by people from other hospitals outside the Bendigo area. This had significant repercussions in the months ahead and formed the basis for much of the conflicts which were to emerge and continue to fester.

The year 1986 also saw the appointment of three new members to the Committee of Management which included a visiting medical officer, a health librarian, and myself. This enabled me to get a better understanding of the politics of organizational decision-making within this small community. When focusing on the various groups as a researcher, I tried to make sure that I wasn't wearing my board member's hat in order to remain impartial and unprejudiced.

On an external basis, the Hospital witnessed a change in the State Government management style with the introduction by the Minister of Health of a Hospital Agreements Programme. The scheme is designated to give the Hospital more autonomy in its operations by allowing management to set long term objectives as well as priority goals and indicators on the volume of service to be delivered in the ensuing years. In other words, the Hospital has to provide a performance indication of its achievement level and be accountable for its subsequent actions in realizing those goals. The Government, in return for this commitment will undertake to fund the Hospital to an agreed level.

Apart from the change brought about by the Agreement, the end of the year saw the Hospital and the health care industry in Victoria plunged into unprecedented industrial action and turmoil. In November and December 1986, nursing staff members of the Royal Australian Nursing Federation withdrew their services from the Hospital for a period of seven weeks. The action was taken in support of demands for a career structure within their wages award. Not only did this result in a reduced level of activity as far as the treatment of patients was concerned and a loss of income by hospital personnel, but the effects of the strike on relations and emotions between staff still lingers on today, to some extent. The enormous conflict that resulted because of the strike will be discussed more fully at a later stage.

It became obvious that this Hospital was a rather complex open system consisting of an extensive division of labour and specialization, an intricate organizational structure, and an elaborate system of co-ordination of tasks, functions and social interaction. The work of doctors, nurses, administrators and others is mutually supplementary, interdependent, and interlocking, requiring a rather intricate and elaborate system of internal co-ordination. Consequently, it is understandable that such an organization is constantly confronted with the challenge of resolving conflict, tension, and friction.

At this point, some comment needs to be made about the agreement or research bargain that was made (if any) in the course of gaining access. As I indicated before, my role as a researcher and the content of the research was explained quite clearly to the Chief Executive Officer who was in charge at that time. The present incumbent was also well aware of my intentions and presence in the Hospital. There was a genuine interest in trying to help as well as providing the basis for a more practical teaching application to hospital staff in general. There was also the feeling that the investigation would uncover aspects or problems which may then, in due course, be changed or corrected. However, at no time was anything specific or explicitly agreed upon, except the obligation to assure an ethical approach on my behalf and the opportunity to read my findings.

SELECTION STRATEGY

Finally, I would like to elaborate on the selection of individual groups and respondents and the role of key informants in the research process. By using the organizational chart and a complete roster of members in different professional and occupational groups and positions, I was able to draw up a list of individuals I wished to interview. The focus of the study was the Hospital as a total organizational system so all the relevant groups, sub-groups and various individuals within it had to be represented. The objective was to interview mainly the "key" players as well as people from all organizational levels of the hierarchical structure. As Sofer indicates:

> "It is often advantageous to make detailed studies of a few of the key roles relevant to the problem under study. These cover the content of work, the duties of the occupant of the role, the obligation of others towards him, the relationships he carries with superiors, colleagues, and subordinates, the social and psychological atmosphere and pressures in and around the role, the opportunities it confers for satisfaction, and the frustrations and difficulties which the man in question is required to tolerate". (Sofer, 1961:135).

Some of the "key" players became important informants; individuals who were (and still are) in a position to experience and observe significant events and objectives, and who were more than willing to communicate these to me in a perceptive and reflective way. These are individuals whom I got to know well and who could explain, clarify and portray aspects of the social situation.

The following people were finally selected as respondents to represent their respective groups and the hospital:

(a) The Chairman of the Committee of Management.

(b) The Hospital Executive (i.e. the Chief Executive Officer (Chief Executive Officer), the Deputy Chief Executive Officer, the Medical Superintendent (MS), and the Director of Nursing (Director of Nursing).

(c) Members of the Medical Staff comprising:
    (i) Visiting Medical Staff (VMO's) (i.e. the vice-president of the medical staff group executive, a general surgeon, an obstetrician, a physician, a paediatrician, and an anaesthetist).
    (ii) Salaried Medical Officer (SMO) (i.e. the casualty supervisor).
    (iii) Resident Medical Officers (RMO's) (i.e. two registrars and two residents').

(d) Medical Ancillary Departments (i.e. the chief pharmacist, the chief physiotherapist, and two social workers).

(e) Members of the Nursing Staff comprising persons in administrative and supervisory positions (e.g. deputy director of nursing, area co-ordinators, night nurse in charge, supervisors, and charge nurses); two senior tutorial staff; and a representative sample of registered nurses, student nurses, and mothercraft nurses.

(f) Members of the General Services Staff (i.e. administrative officer-general, finance manager, chief engineer, deputy food services manager, and domestic services supervisor).

(g) Other staff members comprised a technician, two porters, and two cleaners.

(h) The chaplain.

(i) A few patients from the male surgical ward and the obstetric unit, and several mothers whose children were hospitalized.

(j) An ambulance officer.

SOURCES OF INFORMATION

The choice of my sources of information was influenced by my wish to "tell it like it is" so that I can describe why the people concerned behave the way they do and how they see the situation themselves; only then can I seek causes and explanations with regard to my focus of interest. So, if I am going to interpret the experiences and meanings of social actors and "live amongst the natives" I can only do so by participation with the individuals involved combined with other auxiliary methods of research, such as focused interviews and studying documents of various kinds.

(a) Observation

The longer I stayed in the Hospital, the more I felt I was able to develop a true and authentic understanding of the setting and (hopefully) being able to penetrate the "fronts" that are often put up for an inquisitive researcher. The value of being an observer lies in the opportunity in gathering rich detailed and fully flavoured data based on observation in natural settings (Becker and Geer, 1958). Overall, I had the permission or freedom to penetrate any social situation that I felt was relevant to the investigation.

My personal involvement with the people I was studying varied depending on the event (Gans 1968). Being on the wards or joining people for lunch or tea meant that I participated in that social situations but was only partially involved. Attending meetings (prior to becoming a board member) and carrying out informal interviews, on the other hand, was an observation without any emotional relations. Even if one becomes involved in a social situation, one is aware of one's research role most of the time. Interestingly, as a board member and attending board meetings and sub-committee meetings was a different experience all together. There, I became completely involved emotionally most of the time

and then wrote down afterwards what had happened before. Meetings were very useful from a researcher's point of view because they enabled me to understand the political and administration processes that shaped decision-making in the Hospital.

Apart from the observation itself, establishing relations and developing rapport and trust are a crucial part in an organizational study (Scott 1965). I think what often mattered was people's opinion of me personally, as I indicated earlier, and also the fact that the respondents felt that I was genuinely interested in trying to understand their situation. These aspects play a major role in what is actually communicated to the researcher. For some respondents the interviews enabled them to take a break from the everyday routines of work and some, perhaps, felt flattered that they were the ones chosen to help in the research and interact with someone from an academic institution. For most, I was an interested outsider who had a ready ear and open mind and who was prepared to listen to their grievances and complaints.

In addition, I knew that it was important for me to remain impartial, not to develop political alliances, and not to gravitate towards those respondents who made me feel welcome or because I shared their values or they were easier to talk to. The choice of people I had to talk to was determined by my research topic but, more so, by the fact that the focus was on the whole institution. Overall, I didn't feel any strain in being marginal and neutral.

Where I did feel some degree of anxiety, was during the process of gaining permission for an interview or access to a ward. Occasionally the anxiety intensified when I felt people were very busy, when there was tension in the air, or when I entered especially critical areas of medical care such as the labyrinth of the operating theatre. However, as there was no concealment or secrecy to my research, and because I had the

approval and support from various "gatekeepers", it released many of my inhibitions and tensions regarding the invasion of privacy.

There is, of course, always the worry as to whether everything of importance has been covered; have I missed an event or meeting or perhaps not interviewed somebody who could have given more valuable information.

(b) Interviews

Interviews are extensively used to obtain all different types of data. They can be used to study opinions or attitudes, to obtain factual information, or to study the emotional reactions of help to other individuals, or events. Most of the respondents were interviewed privately either in the hospital, the surgery, or their private house.

Because of the nature of my research I preferred to use an informal or semi-structured style of interviewing with a certain focus on some relevant themes and topics which were brought up for consideration and that could subsequently be compared. That is, I designed an agenda of topics or themes - questions which were applicable to all concerned and some that were only appropriate (but remained the same) for specific "key" respondents and main groups. However, there was no attempt to force a person to answer in any special manner, or in a set period of time. Some interviews were tape recorded; with others I took notes. I tried not to get too heavy into tapes because they tend to blunt the sensitivities. There is always that amount of caution on behalf of the interviewee because the recorder carries that indication that there is a third party present. However, it is useful in checking the data or the order of things.

My curiosity was to find out where people were at, and always made sure to write down the salient points afterwards. Interviews were useful because they provided feelings and reactions and a back up to check on my own recollections. Again, as with participant observation, the rapport between the researcher and the subject is important. I made sure that each time I interviewed someone I explained the reason for my interview and that the material would be used to write a thesis.

Most of my anxiety relating to interviews concerned the visiting medical staff. Rosengren (1980) points out, that it is often extremely difficult to engage the approval and co-operation of a medical practitioner due to considerable suspicion and a feeling of some kind of threat to the established order of things in the medical setting. Moreover, given the highly scientific and technical nature of medical education and practice, social scientists are stereotyped as rather odd; "fuzzy" in their thinking and basically of little practical use. Most medical staff don't quite understand what research is all about (technology is quite different to sociology).

I found that once I became a member of the Committee of Management I was able to gain acceptance more easily. Perhaps it was because this gave me a legitimate place in the scheme of things; that is, a meaningful location within the structure of the Hospital. It may well be that they also felt that perhaps something could be done on my part in overcoming some of the problems facing the institution and their own situation. They had to learn what I was doing so that they could see that there is something connected to their interest, and so there should be. It's a matter of getting their trust and confidence and building up credit with them by showing them the things that they suspected.

I tried to see the world from their standpoint by trying to meet them at the point of task orientation. That is, what do they meet when they try to work and why are they behaving the way that they do? I made it clear to them that I wasn't here to moan or complain about them, but was interested to see whether the system is working and whether it was healthy.

I was always well aware how extremely difficult it was for some of these medical specialists to give up their valuable time. I was patient in waiting and when the time came I expressed my appreciation of that fact and received some invaluable information in return. Properly formulated and carefully conducted (monitoring the direction, depth, detail and topic coverage) the interview itself can reveal some profound social facts and opinions.

I found it interesting that during my observations and interviews with person I could often identify myself and my behaviour. It became more than just an interest, but an opportunity for both of us to reflect about ourselves. It was a journey of self-analysis and exploration - an overlap between me and my research.

(c) Documents

In my study of the Hospital I also had at my disposal certain documents which bore a direct relation to the people and events in question, providing a useful resource to back up or complement evidence gained from the other methods of field research. Like Dalton (1959), I made use of organizational charts and formal job descriptions to understand the network of positions through which the institution operates but also as a baseline with which I could compare the "defacto" functions and responsibilities of the key players.

In addition, my sources included minutes from meetings, letters, governmental publications, architectual plans and historical documents. This material was quite numerous and decisions had to be made, which to select and where to place the emphasis.

The principal techniques that I have used in conducting my field research are: observation, flexibly structured interviews and conversations, and the use of documentary evidence. Combined,

> "they emphasize the importance of studying social life in its natural setting, and describing it as it is seen and experienced by those involved" (McNeill 1985:113).

Contacts with other hospitals

I have always been interested in hospitals since my involvement in lecturing to charge nurses. Right throughout the study I have been in touch with these nurses from the various hospitals in the region.

In 1985 I spent some time at the Psychiatric Centre in Bendigo looking around the place. Unfortunately, my application to conduct research there was turned down by the Superintendent who felt that it was not in the best interests of the Centre at that time.

Whilst in Bath in 1987, I visited Swindon with Geoffrey Hutton, and was introduced to Trevor Goodman, the District General Manager, and to some of the consultants in the Princess Margaret Hospital. I also went to Trowbridge because of my interest in the midwifery unit.

These contacts with other hospitals enabled me to bring a comparative view to the BBH. I have used the Trowbridge case for comparison purposes in Chapter 15, relating to the Maternity Wing.

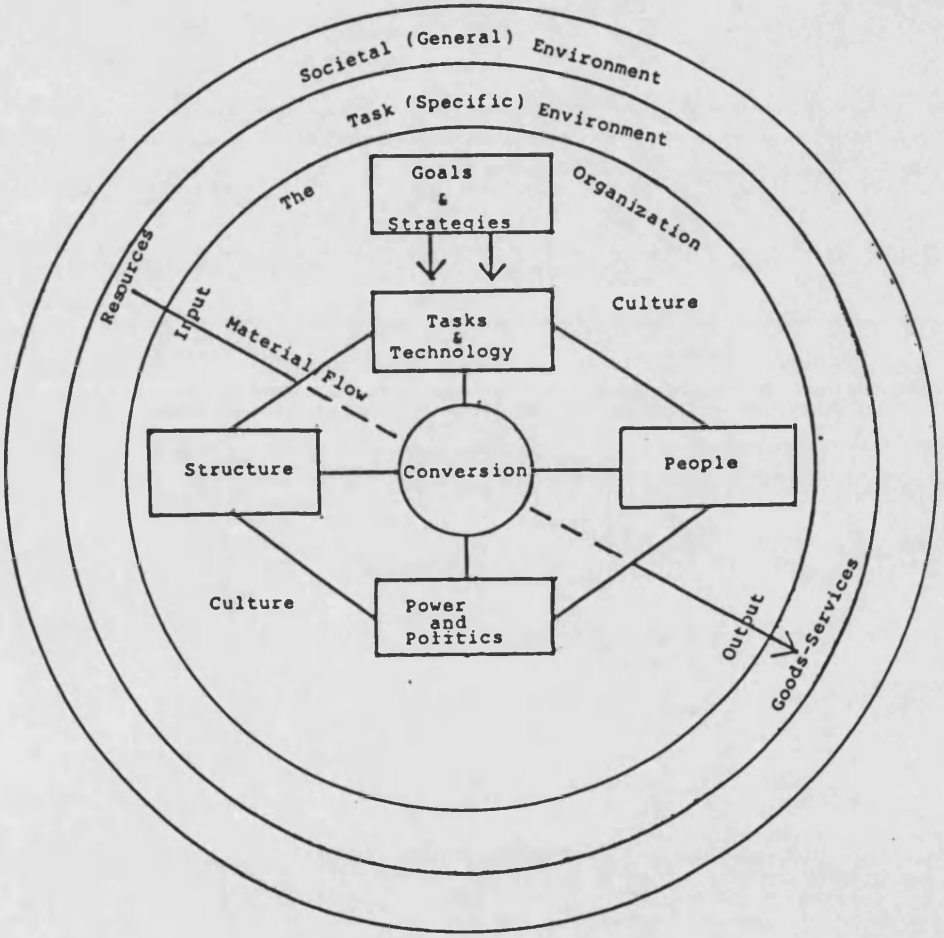
CHAPTER 2
THE ORGANIZATIONAL FRAMEWORK

I would now like to throw some light on how I formed a framework for helping me to interpret the conflict process with the Bendigo Base Hospital. The longer I immersed myself into this unique culture, the more I became aware of the complexity of this institution, and the more it appeared as a territory full of conflict.

What I needed was a personal map which would give me some direction through this organizational minefield. It had to be something that I could use as my own heuristic guide. Consequently I developed my own organizational and environment framework from which I could find my way to where the conflicts lie. In the first two years, I reviewed the organization theory literature from this new perspective. As a result I chose what I felt were the key variables which in total formed the theoretical context for my study. Although the model may seem somewhat academic and requires some analysis and description, its aim is to relate my curiosity to reality: that is, it helped me to deal with actual on-going events. It is about me and my experience in the BBH and not so much about the literature. Nevertheless, it helped me to relate what I saw to what I read about.

It is based to a considerable extent on socio-technical approaches to organization, and therefore takes into account the notions of relations with environment, tasks and technology, differentiation into structure, the people, and the social system. The diagram in Figure 1 is not meant to be taken too literally. It cannot conveniently show all possible interconnections. These interconnections are meant to be assumed.

Figure 1. A map of the field of conflict.



The model is based on the assumption that conflict emerges out of the field shown. Conflict is a function of the various organizational features, or of their impact on each other, or of the dynamic interplay of the organization with its environment. Patterns of relations emerge between the components which become the primary determinants of conflict. I shall discuss this in the next chapter.

I will now discuss in more detail the various major components which make up the framework, and their usefulness in my research.

OPEN SOCIO-TECHNICAL SYSTEMS

A complex organization like a hospital:
"consists of many different, but interlocking and interdependent, parts - departments, staffs, positions, work roles; it possesses certain human and material resources and facilities and is designed to pursue certain objectives. It is a highly specialized and internally differentiated system which is intended to do certain work in order to solve particular human problems. It is a work-performing sociotechnical system that can generate certain outcomes through the proper utilization of human energy and knowledge, the careful use of physical resources and technical facilities, and the collective co-ordination, regulation, and intergration of the functions and activities of its many human and non-human components" (Georgopolous, 1972:9).

One way of analyzing the organization of a hospital is based on the concept of open, socio-technical systems theory. This concept has guided my thinking and helped me to organize my research. It has enabled me to cope with the analysis of this complex phenomena by identifying key focal elements and their interrelations.

A system can be defined as a series of interrelated and interdependent parts or subsystems and delineated by identifiable boundaries from its environment. The system is open by admitting continuous inputs (raw materials and resources) from the environment, converting them and sending these outputs (products or services) back into the environment in order to achieve a "steady state" or dynamic equilibrium (von Bertalanffy, 1951).

The conversion activities of the system are measured by the difference between what it imports and what it exports. Providing the primary task (sophisticated task) is achieved by

maintaining the quality of its outputs, the organization will receive resources from the environment in order to attract further other inputs. The primary task is the task that must be performed if the organization is to survive. In the same way each section in the complex organization has its own discrete sub-primary task, each contributing to the primary task of the whole (Rice, 1963).

The idea of the socio-technical system, (a notion which started off with production systems) stresses the structuring and integration of human activities and sentiments around various technologies in pursuit of some common ends (Emery, 1969; Emery and Trist, 1959). All may be seen in mutual interaction with each other and with the environment in which the organization is embedded. The technical system (task requirements, physical layout, equipment available) and the social system (the psychology and the sociology of the people) are interrelated and each determines the other to some degree (Homans, 1950; Trist and Bamforth, 1951).

Tasks are a variety of activities performed by individuals or groups using some type of technology and physical behaviour. The social system deals with people and their perceptions, personalities, roles and statuses and the way they use the technology and the effects, opportunities and limitations produced by it. The limitations involved in the task are set by the physical designs and the physical things and the method in which the work flow is organized. Each technology, itself, has its own set of constrained limitations on behaviour.

Overall it becomes a question of co-operative efforts of people to use the technology in achieving some common goal. The machinery is there and the material flows but it only does that because people have chosen it and bought it and put it into that relation though it works in accordance with physical laws.

System boundaries

Boundaries exist between a system and its envronment. A complex system is characterized by the existence of internal boundaries. Boundaries imply discontinuity in tasks and the insertion of a region of control. It is a region in which elements of task systems and their environments come together.

The starting-point in analysing the structure of a socio-technical system is to differentiate the various operating and managing systems. Operating systems are the task systems that are concerned with some stage of the dominant input-conversion-output process through which the primary task is performed. Consequently, the analysis of the boundary of an operating system can be based on an analysis of work flow by asking where is the discontinuity. Where the action changes, a boundary has been crossed.

There are various bases for differentiating between operating systems. Miller (1959) has suggested three principles,, mainly, technology, territory, and time. Technology refers to the material means, techniques, and skills required; territory refers to the physical layout; and time means shifts or other work periods. Mintzberg (1979) differentiates on the bases of function (work process and function; knowledge and skill), which corresponds with Miller's analysis. He also discusses differentiation by market (output; client; place). Time differentiation occurs with both function and market. With each approach there is a large number of combinations of the various dimensions in question.

The systems idea has helped me to develop a more diagnostic point of view toward organizational behaviour by examining behaviour at various levels. My approach follows a scale or building block process from the individual, through the groups, to subsystems (department and division), to the

organization itself, and to its community and environment. In open systems theory each system is composed of subsystems; that is, systems are nested within systems so that each level operates in the environment that is provided by the next higher level. In this sense, the organization can be regarded as an ecological system. There are therefore boundaries and compromises to be made between objectives at each level (Hutton, 1972).

When we look at tasks, flows and structures, we are looking at them from a technical point of view; that is, why and where are the flows and structures in the technology? When we look at the principles on which people organize their social activities (especially the aspect of power because of the curiosity about conflict) we are asking sociological questions about the flows and structures in the various things to do with people.

We are confronted with a mini society where people organizing their actions about purposes. They are using technology and relating to each other, and differentiating and co-ordinating around the task. Moreover, people are also organizing their activities related to profession, status, rank, and prestige; or simply because they like, or dislike each other. Whatever the situation there are boundaries because whenever people organize around some principle, a boundary is set up.

When there is more than one operating system or subsystem a differentiated management system is required to control, co-ordinate, and service the activities of these various operating systems. This will comprise the management of the total organization, managing each discrete operating system, and also management of the non-operating systems such as control, maintenance and facilitation.

It is useful to distinguish between task boundaries, organizational or management boundaries and group boundaries. A task boundary distinguishes discontinuties which exist in the task

system, as for instance around a patients, a ward or an operation. Organizational boundaries are those around a department or a division. Within the Hospital, examples are the medical, nursing paramedical or administative divisions. Groups may form around a complete task, like the operating team in an surgical operation (task groups). There may also be groups with which members identify or feel some loyalty to. The attachment group (Hutton, 1972) may be a professional group. Such groups are strong in hospitals.

Conflict may arise where the organizational boundaries and the attachment boundaries do not coincide with task boundaries. In the ward or operating theatre, for instance, a number of professional divisions or professional groups come together on the common task.

Enterprises and their sub-divisions can usually be seen to have a number of tasks. For instance, a hospital has treatment, training and research tasks. The tasks form an array or mix.

The relative emphasis upon one or another of these major tasks will vary with the type of organization and the nature of the work that is being done; that is, the imperatives of the particular task system that is most critical at the time will determine its importance. Thus primary task may change over time depending on what is going on. Time changes the emphasis when there is a major process that is not intrinsically controllable or external environments that are unpredictable as to how they will impinge on the organization. According to Mary Parker Follet, the law of the situation is the primary task.

There may, too, be different interpretations of the primary task of the organization depending on what group or individual you talk to or depending on whether you are on the inside or on the outside looking in. Thus the primary task becomes a collective or collusive idea. Different interpretations can be in conflict and

in competition. People have different representations of the phenomena, each person regarding their view as reality.

The difference is also reflected in when we question people as to what they see as the primary task, and then look at what they are actually doing. It could be just all rhetoric or espoused theory whereas their actions and the reality are quite different. Change processes, such as those relating to technology, for example, where things have to be rearranged or carried out differently, will often change the espoused theory or beliefs.

To achieve the primary task various major tasks have to be accomplished which for our purposes can be categorized into three different processes or task systems. Hutton (1972) refers to these major processes of the organization as boundary management, goal achievement, and system maintenance.

(a) The boundary management (strategic apex) task is to direct the organization by managing the relations between the system as well as managing the flow across the boundary linking the organization with the external environment.

(b) The goal achievement or transformation tasks are those that work directly on the material (operating core); those activities which are concerned with partly servicing or facilitating them; and those which control (regulate) the performance of the operational process.

(c) The system maintenance activities are concerned with acquiring and allocating needed resources, developing the system, and the maintenance of performance of people and machines.

GOALS AND STRATEGY

Organizational goals

The goals of an organization provide the basic sense of direction for its activities. They represent the desired future conditions that the organization strives to achieve. We will use the word "goals" to include overall purpose or mission and objectives; the former representing the higher level in the ordering of direction. It is important to mention at the outset, that goal statements usually reflect the history of the organization. A reading of the history and tradition helps explain the societal factors that influenced the birth and development of the organization. This "historical novel" may also reveal noteworthy individuals who influenced the course of the institution, interesting happenings, and the way, the organization sought to adjust to the impact of the political and financial forces from the environment.

A mission statement broadly defines the purposes for which the enterprise exists. Often, it includes, and usually reflects, the values of the leaders of the organization and those of the environment. The missions the types of services and the clients served.

Within an overall mission, an objective is an end result or target that aimed for. Objectives connote greater degrees of specificity and serve to translate the mission into specific concrete terms against which results can be measured. They too have value orientations and reflect desired conditions considered necessary to improve the overall performance of the organization. Overall objectives also indicate more specific sub-objectives, policies, programs and plans. However, the objectives of an organization are seldom as clear cut as they seem.

The stated mission and goals may not be those actually being pusued. As Perrow (1961:854) indicates:

> "... the type of goals most relevant to understanding organizational behaviour are not the official goals, but those that are embedded in major operating policies and daily decisions of the personnel ... these goals will be shaped by the particular problems or tasks an organization must emphasize since these tasks determine the characteristics of those who will dominate the organization."

Each of the task areas is controlled or dominated by the group composed to work it. Operative goals are shaped by that dominant group, reflecting the imperativees of the particular task, and the characteristics of the group.

The organization may be seen as a coalition of many subsystems and participants, with multiple goals frequently not officially stated and often in conflict. In order to understand this complexity more fully, Kast and Rosenzweig (1979) suggest a closer look at the various forces influencing organizational goal setting, namely from three primary perspectives - the environmental level, the organizational level, and the individual level. Responding and adapting to environmental opportunities, demands, and constraints, for example, leads to continual modification and elaboration in the organization's own goals. In addition, subsystems which are differentiated by function, also establish their own subgoals which frequently leads to interdepartmental conflict.

It is unrealistic to expect a harmonious match between organizational goals and the personal needs of individual participants. Perfect compatibility and optimal satisfaction is impossible and conflict often results. Few participants commit themselves fully to meeting organizational goals. They also have career goals. and requirements for the nature of th their work and

surroundings. The internal struggles and political intrigue that career goals involve may dovert much effort from the tasks of the organization.

Strategy

Strategy is the broad program or pattern of managerial decisions for achieving an organization's objectives and thereby implementing its mission.

The organization as an open system functions within a larger open environment. Strategy can also be defined as the pattern of the organization's response to its environment over time. The environment provides opportunities for action and constraints on activities, as well as making demands upon the organization's capacities. Strategy links the human, technological, and managerial capabilities of the organization, on the one hand, with those challenges and risks, on the other. Managers respond and adjust to the environment by determining how their resources can best be used to function within the environment. The priorities of the organization are therefore relected in resource allocation. Usually, substantial resources are given to those departments that have the responsibility for achieving the core (operational) activities or main goals.

TECHNOLOGY

The type of technology that exists in an organization is determined by the task requirements and is shaped by the specialization of knowledge required, the tools and equipment involved, and the layout of facilities. In short, technology consists of the complex of techniques or methods used that transform organizational inputs into outputs.

Before developing the notion of technology further, I think it is important to clarify the inclusion of knowledge and skill in the definition of technology. The knowledge base for professionals, for example, is gained from the environment through educational institutions. The use of skill in the task of working on the material during the throughput process can only be understood in the context of the socio-technical system. The skill is how people relate to the technical system by using certain tools. The technology is not the skill but the tool is, and what the tool or machinery can do to the material. The competence of the person is in handling the physical objects but what these objects can or can't do is the technology.

For example, if somebody cuts something or has the physical control over the material worked on, it is an activity which belongs to both the technical as well as the social system. The articulation between the two systems is at the point where there occurs a unique event; where somebody does something technical and that particular moment belongs to both systems.

In large complex organizations, we find that technologies cover a wide range of activities so that it is useful to analyze the technology at both organizational and departmental levels. In terms of the systems theory the organization-level technology is related to the operational (throughput) process or operating core.

Organizational technology produces the principal product or service of the organization. Moreover, different technologies are used in different parts of the organization. But, although technologies are mixed, the operating core identifies the central pervading technology as distinct from the subsidiary ones (Yuill, 1970).

Complex technologies used to accomplish the primary task of the Hospital have an important impact on its sturucture and social relations. In addition, scietific and technological chages in the environment have a strong influece on the technical procedure within the Hospital.

STRUCTURE

The structure of an organization involves the ways in which tasks are divided and co-ordinated with some degree of permanency. In complex organizations, the structure is reflected by the design of the major subsystems and by the established patterns of relations among these subsystems. Kast and Rosenzweig indicate that the formal structure is frequently defined in terms of:

1. The pattern of formal relations and duties - the organization chart plus job descriptions or position guides.
2. The way in which the various activities or tasks are assigned to different departments and/or people in the organization (differentiation).
3. The way in which these separat4 activities or tasks are co-ordinated (integration).
4. The power, status, and hierarchical relations within the organization (authority system).
5. The planned and formalized policies, procedures, and controls that guide the activities and relations of people in the organization (administative system)."

(Kast and Rosenzweig 1979:198)

A great deal of literature deals with the structural aspect of organization in this wasy. Others take adopt a dimensional approach such as that of the Aston studies (Pugh et al., 1968). My approach, however, is a more ecological view developed from the socio-technical notions.

The recognition that organizations are complex social systems indicates the significance of studying organizational behaviour. The primary concen in this perspective is with human beings; and the ways in which they behave and interact in the total organization. Even more so, it is dealing with the actions and reactions of groups, subsystems, and the total organization in

response to internal and external stimuli.

This behaviour occurs as people seek to integrate the technical and the social systems. Characteristic patterns of communication, power, conflict, adjustment and coping with change become established and permeate the organization. People establish the ethos: the customs, the choices, the way things are done, the way conflicts are handled.

Approaching conflict from a socio-technical perspectrive inclines me to look for multi-level explanation or understanding. For instance, looking at intra-group conflict lead to all sorts of observations of what you see at that level, and raises the question to what extent we need to go higher and lower to understand it. Explanations come downwards as well as upwards and it is only by prodding that we can find out where the problem lies. The most powerful sources of causal explanation are the subsystems themselves, and the systems at the levels above and below. It may be clear that I am not seeking explanations of a mechanistic character, but am approaching more with the idea of contextual causation.

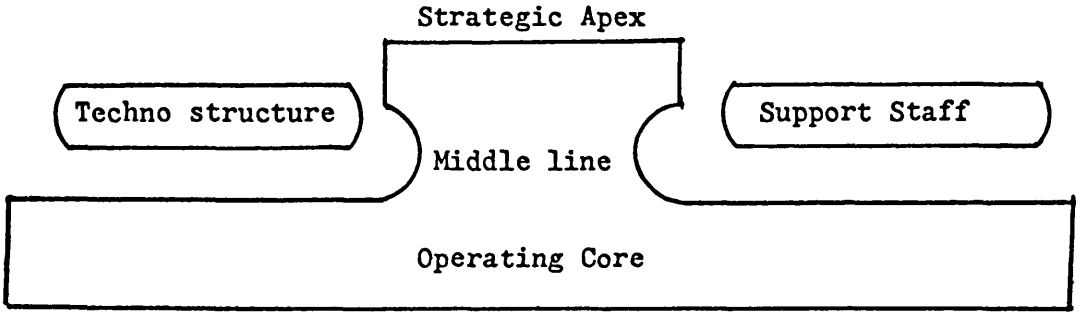
Work structure

The concept of work structure identifies the organization as a formal social structure consisting of various well developed social positions and task groups, highly interdependent and interrelated which are analyzed in terms of subsystems nested in hierarchical form. Each subsystem described has an identifiable boundary. The manager or gatekeeper for each subsystem helps to maintain the boundaries.

The need for increasing efficiency results in even greater degrees of specialization. This, in turn, places greater demands upon the social system to integrate and coordinate its subsystems.

I find it useful to apply Mintzberg's model of analyzing organization structure in terms of its major layers or parts: operating core, strategic apex, middle line, techno-structure, and support staff. (Mintzberg, 1979). The relative size and importance of these five organizational parts and their component positions vary in different type of organizations depending upon the overall environment, technology, and strategy. Mintzberg proposes that these organizational parts could fit together in five basic configurations : (1) simple structure, (2) machine bureaucracy, (3) professional bureaucracy, (4) divisionalized form, (5) adhocracy. The "professional bureaucracy" is suitable for my analysis as illustrated in Figure 2.

Figure 2: The professional bureaucracy



Source: H. Mintzberg, The Structuring of Organizations, 1979:355

The operating or production core, which is the key part of the organization, is composed of professionals. It is concerned with carrying out the basic work of the organization, namely rendering a service, effectively and of high quality. While the

organization is bureaucratized, the people in the production core have most of the power and autonomy. Long training and experience encourage low control, and reduce the need for bureaucratic control structures. The operating core is primarily concerned with transformation tasks involved in producing outputs from inputs. In addition it encompasses various input and output tasks.

The strategic apex is composed of the board of trustees and top management concerned with the overall mission of the ogranization, allocating resources, directing the organization, and managing its relations with the external enironment. The middle managers are responsible to link the strategic apex with the technical core. The technostructure or technical support staff (engineers, researchers, and analysists) are small but large administrative support groups are needed to handle the organization's routine administrative affairs.

Work flow

The structural view of the organization presents the static features of the system. The work flow perspective puts a more dynamic focus into the study by analyzing the ongoing activities.

This perspective of an organization, and especially of subsystems within it, is essentially horizontal, as it captures the ways by which work flows through the open system. Organizations are basically structured to capture and direct systems of flows thereby defining interrelations among different parts. My perspective is to view how the "human material" is taken into the organization, is then altered in a predetermined manner through a series of activities (Perrow, 1965), and finally returns back to the environment.

PEOPLE

When we talk of people we are focusing on individuals and groups in interaction. That is, we are dealing with the behaviour of individuals, group dynamics, intergroup relations as well as the total organization responding to internal and external opportunities and constraints.

For all of these individuals, the organization exists as a social entity in which they, the human actors, fulfill organizational roles through active initiation and reaction in the process of face-to-face interactions. It is the whole person we are looking at, with his or her values, attitudes, sentiments and motives together with his or her expectations and aspirations. Or in the words of Mangham, (1979:21) "a sensing, perceiving, interpreting, choosing and adaptive central actor in social situations."

When I think of the "whole person" I mean the integration of several inherent and acquired characteristics: biographical characteristics, personality, values, attitudes, abilities, perception, motivation, and learning all influence a person's behaviour.

In interpreting our environment, we form a picture which fits our values and beliefs based on past experience. Apart from the values, attitudes, and experiences that the individual brings from outside, perception is affected by the person's position, the encounters and experiences associated with it. Organizational problems are interpreted from the point of view of the function of the subsystem or department one is working in and of one's hierarchical position.

However, as we already indicated, people are linked or related to more than one group which influence their opinions and attitudes. People use these groups as reference groups in order

to clarify or guide their perceptions. Gouldner (1957) classifies reference groups on the basis of whether they are inside or outside the organization of which the person is a member. Professionals, for example, tend to express a strong need for recognition and approval in their own field of expertise by colleagues outside of their present organization. Such a person is identified as a "cosmopolitan". Formal job requirements are often responded as uninteresting and hampering their professional development.

On the other hand, people we can call "locals" tend to have their reference groups within the organization of which they are members and to which they exhibit a strong loyalty. Changes which are made to benefit the organization are usually seen by these members in a far more tolerant and understanding way.

When people are grouped together structurally into work units one finds a common focus being reinforced among the work group members. The norms of the subgroup play an important role in influencing individual behaviour. That focus is inherently limited and is a divert outcome of selective perception and cognitive limits. Because different subsystems represent different professions, the unique characteristic of each profession is reinforced so that people identify with that particular subunit. Events are interpreted from that particular subcultural perspective; where you stand on an issue depends upon where you sit (Mangham, 1979).

Schein (1980) also makes the point that deciding to join the organization implies that the new member will accept the authority system of that organization. However, occasions arise, where one or both of the parties feel that the other party is not keeping to their side of the bargain and will try to force the issue. That is, the organization can enforce its side of the contract through the use of authority and the exercise of power. The employee, on the other hand, can enforce his or her side of

the contract by quitting, going on strike, sabotage, and other means. The pattern of authority and influence that develops in an organization will depend on the extent to which members will consent voluntarily to submit to authority.

It is not just as simple as all that, however, because in the hospital scene there is a whole variety of different ways of accomodating to authority.

Etzioni (1961) categorizes organizations according to the type of psychological contract that they have with their members using compliance as the major source of differentiation. The compliance structure is determined by the kinds of power or authority (coercive, calculative and normative) applied to lower-level participants. The type of power or authority used in turn will influence the kind of involvement being elicited from the member of the organization.

Etzioni's "pure" types of organization are seldom found in reality as most organizations are a mixture of several types. There are even variations amongst the various subsystems within the organization and members themselves may individually occupy different positions with regard to the particular types of involvement.

This variation is again quite typical in the case of the Hospital. Etzioni classifies hospitals as normative. Although normative compliance is strong in the Hospital, the coersive and calculative types also play their part.

Status

A position which an individual occupies within a group or organization is associated with a rank or prestige grading known as status. Status hierarchies have always been part of the social system and develop among individuals in any group. The

organizational status system shows the way in which the rights, privileges, duties, and obligations are distributed among the members. The system not only reflects the political scenario within the organization but the social structure of society generally. The hierarchy of occupational prestige (allied to educational achievement and skill) is one of the most basic systems of ranking.

> "Occupational prestige is important in the social system because it affects the power and influence of occupants of certain positions, as well as the amount of resources that society places at their disposal." (Kast and Rosenzweig 1979:266).

The question of status is a conflictful issue in the Hospital because of the different interpretations that people put on it.

POWER

The concept of power is of central importance in the process of negotiating order and forms the basis of all social and organizational behaviour. Politics in organizations involves the tactical use of power by individuals and groups to retain or obtain control of real or symbolic resources (Bacharach and Lawler, 1980). Moreover, politics serves the interests of those possessing power and works against those who are less powerful. Power which is acquired and essentially held by political means, becomes a priority commodity to be effectively wheeled and dealed. Both power and politics are thus closely related.

In the literature on organizations, the terms "influence", "power", and "authority" have been used in a variety of ways. Power to me is the ability or potential to influence others to behave in a certain way. Influence is the actual change which is produced.

In the BBH, some people use these words in a different way. For example, people will say that they do not have anuy power but a lot of influence. From my point of view, they do in fact have power, but may not have official authority.

The concept of authority differs from power, but contributes to it. Authority refers to power which is exercised by virtue of legitimate rights. These rights come primarily from official positions, but can also come from professional expertise. I will refer to official and professional authority.

Most theorists view power as embedded in the social relations and not an attribute of the actor, group or organization, as do I. However, power is not only restricted to an individualistic or interpersonal context but should also be examined on the interaction between organizational units or subsystems. Although power is used by individuals, in the organizational context it can

also be used by them as members of their group. Whatever the unit of analysis (individual, group, or organization) the interactional dynamics of power relations are the important focus. Who are the key actors and groups that are interacting and competing vis-a-vis each other becomes the critical question.

CULTURE

Anyone who has worked in more than two or three organizations, will have been struck by the differing atmospheres, the kinds of personalities, the way people organize their affairs with each other, the customs, the choices that are made, and the manner in which conflict is handled. It is that something that is specific or unique to that particular organization; that something we call culture. The concept is used holistically to characterize and differentiate one social system from another.

We can ask about the history or set of traditions that have influenced the philosophy, mission or primary task of the organization; the way the environment and the technology is handled; of roles and their structured positioning and how they are formalized; of people and how they behave in those roles with their values, attitudes, perceptions and motivations; and the way power, status, authority, and influence determine the allocation of resources.

All this is asking questions about the culture. We have a mixture here that makes the organization for what it is; it is the culture.

We cannot really define culture precisely, for it is something that is perceived, visible, or felt. Organizational culture is real and has impact, whether we are talking about an organization, a functional unit, a group, or an occupation, The fact that a social unit looks and feels different from another social unit is reflected in the pattern of basic, long-standing assumptions or behaviours that have worked in the past and are taught to new members as the correct way to perceive, to feel, to think, and to act (del Bueno, 1986). That is, culture offers a pattern for behaviour if members choose to conform to it; not something static but an emergent, negotiated pattern.

Culture, then, is the combination of the symbols, language, assumptions, and behaviours that make up an organization's shared norms and values. Those norms and values are reflected in the stories, myths, and rituals which become symbols of shared principles and purposes; the things that are legitimate and acceptable. But it is more than that. It also includes the artifacts: that is, the technoligy and the contructed physical environment.

Myth and ritual. Myths describe the organization by giving a narrative of events in dramatic form. They anchor the present in the past and provide explanations and legitimacy for current practices (Pettigrew, 1979). Rituals are time-honored customs that provide a shared experience of belonging and express and reinforce what is valued. It is partly through rituals that social relations become stylized, conventionalized, and prescribed. Individuals use rituals to reduce uncertainty and anxiety. Examples are committee meetings, performance appraisals or training programmes.

Policies and practices. Cultural norms and values are also reflected in policies and practices related to personal appearance, dress, social decorum, status symbols, intimacy, and the communication system or style. Compliance expectations of those policies and practices may differ from organization to organization and for different gender and occupations.

Language. Many organizations and subunits within organizations use language as a way to identify members. Acronyms and jargon act on common denominators that unite members of a given culture or subculture.

Subcultures

If we view culture as a property of an independently defined stable social unit, then we are saying that the members of that unit have shared basic assumptions and beliefs about the world around them and their place in it. So, when we talk of organizational culture we expect that the members with different backgrounds or at different levels in the hierarchy share a common understanding and behaviour. We can acknowledge this, but we must also take note of the fact that the organization should not be treated as too homogeneous and that there are subcultures operating within any given culture. Most large and complex organizations have a dominant or prevailing culture as well as numerous sets of subcultures or behaviour systems (Gregory, 1983). According to Sofer (1972:352):

> "conflict between functional groups is often exacerbated or consolidated by what are in effect cultural differences in regard to values, beliefs, outlook and habits of thinking. Persons grouped together on the basis of similar training, qualifications, or tasks characteristically develop ideologies that emphasize their distinctive contributions to organizational ends and their unique place in the social division of labour".

Each department or division in an organization, with its unique tasks tends to interpret any new idea or change in terms of its potential impact on the well-being of its members.

A dominant culture expresses the core values and norms that are shared by a majority of the organization's members. It is this macro view of culture that gives an organization its ethos and distinct personality. In the Hospital, the dominance of the therapeutic process is clear.

Subcultures form because of functional differences (Lawrence and Lorsch, 1967), gender differences, socio economic differences, common occupation, and physical proximity. In each case the core values are essentially retained but somewhat modified to reflect the social unit's distinct situation. The more intensely held the values, the stronger the culture. A strong organizational culture, in turn, increases behavioural consistency and may act as a substitute for formalization (Deal and Kennedy, 1982).

Nevertheless, subunits usually come into conflict with one another which can lead to problems for management if the subculture's norms and values are incongruent with those of the larger prevailing culture. Schein (1985) points out that once a subunit acquires a history, it also acquires a culture. If there is conflict between the groups, that conflict is difficult to reduce.

Because a group needs to maintain its identity it does so by comparing itself with other groups which in turnhelps to build and maintain intra group culture. So, when groups don't get along and find it difficult to collaborate, the problems become, essentially, an intercultural one.

If people seek to introduce changes to the technology or the procedures, it is not just a change in them per se which is at issue, but the challenge to the culture. It is that which gives rise to conflict.

ENVIRONMENT

Environment influences the purposes and goals of an organization by presenting constraints and opportunities through the inputs it can provide (e.g. patients and funds) and the outputs it can accept, thereby indirectly affecting its work. It is also the technical changes that occur in the environment which affecet what can be done within the conversion processes of the organization, especially so in medicine.

However, the environment also affects work indirectly, for example, by prescribing how work is to be done by accrediting bodies and regulatory agencies; by providing the training and education of the members; and by the fact that people interact with other people outside which affects the way they think and behave inside the organization.

It is also important to note that not only do environments vary from organization to organization but the sub-units within an organization focus on different respective areas of the internal and external environment. Each sub-unit has a boundary separating it from other sub-units within the organization as well as a boundary that faces the organization's external environment.

Boundary-spanning activities

Organizations attempt to manage their environment by establishing boundary-spanning activities. These boundary-spanning activities are conceived of as a link or intervening agency between the organization and the environment.

When the environment is dynamic and heterogeneous, the organization establishes functional subunits or departments necessary to deal with a specific set of environmental inputs or outputs. The more uncertain the environment, the more complex and differentiated the internal structuring of the organization.

Examples of boundary-spanning departments in business enterprises are personnel, purchasing, sales, and public relations. In the Hospital, they include the Chief Executive Officer, purchasing, admissions and all the visiting medical staff.

These boundary-spanning positions are often stressful as they create conflict and ambiguity. The agents are caught in the middle which involves having to respond both to expectations of their own department or organization and to expectation of representatives of groups or organizations in the environment on which their organization depends (Kahn et al, 1964). In addition, these people also frequently get caught in cross fires even around their own constituents who have varying biased conceptions of the agent's role.

CHAPTER 3
CONFLICT

AWARENESS OF CONFLICT

The phenomenon of conflict, in the sense of clash of objective interests, is an inevitable and integral part of social and organizational life. Whatever social unit we focus on, from nations and communities through to organizations and the relations of groups and individuals within them, one finds plurality, uncertainty, change and conflict. A study of the history of man is a study in the history of war whether politically, economically, religiously, or philosophically inspired.

We are aware of the great ideological conflict between East and West; communism, capitalism, and socialism battle for the hearts and minds of the global community; and religious differences play their part in conflicts between Christian and Muslim factions in Lebanon and the Catholic and Protestant strife in Northern Ireland. Other conflicts see one people fight against another in civil war be it in Sri Lanka, El Salvador and in the Philippines or the ongoing turmoil in India's Punjab and the Basque region in Spain.

On the home front political parties, communities, councils, and marriages are racked by antagonism, sabotage, discord, and verbal abuse. Nothing is ideal nor perfect and people live, work and play within a web of social relations many of which involve clashes of interests and perceived differences between two or more individuals or groups.

Conflict is endemic to most organizations and there is a growing recognition of its importance. Katz and Kahn (1966) and Mintzberg (1973) perceived the adjudicating of conflicting

demands to be one of the main functions of top management. A study of middle- and top-level executives by the American Management Association, found that the average manager spends approximately 20 percent of his or her time dealing with conflict (Thomas and Schmidt, 1976). Conflict in organizations may occur at any level - between individuals, between individuals and groups, and between groups themselves.

In every organization there are occasions for conflict since members have different perceptions concerning the organization goals, values, priorities and methods of operation. There are clashes between different subcultures reflected in different values and norms; tension builds up between what is and what some individuals or groups feel ought to be; and conflict between vested interests and groups or their representatives demanding an equal or greater share of power and status.

Conflict may also arise between individuals because of differences in values, interests or desires, or simply occur as a result of scarcity of resources and ambition and status rivalry. It affects peaceful existence, morale, performance and communication. Each side of the party (whether manager and subordinate, father and son, husband and wife, teacher and pupil, etc.) feels that their perception of "reality" is the right one and that they have acted rationally and correctly. The real cause of breakdown may not be so much a lack of knowledge or conflict of interests but a collision of values. We live in a world of many contradictions where many issues today are value laden and full of controversy.

In addition, we as individuals experience conflict within ourselves which becomes an integral part of our life. The classic notion of conflict in psychology is that we are often forced to make a choice between commitments that lead in opposite directions. We cannot satisfy them both so we're in a fix which means a choice of some sort. The scope and intensity of such

conflict depend, largely, on our lifestyle and the type of society we live in.

Most people view conflict as dysfunctional, disruptive, disintegrative, dissociative and corroding. On the contrary, far from resulting in a negative outcome, a certain degree of conflict is an essential element in group formation and the persistence of group life as well as aiding the development of the individual. Because of conflict we often become more active, exhilirating, contriving and inventive.

My interest in conflict

My interest in the concept of conflict developed through my experiences of situations and events culminating in numerous encounters with individuals, groups and organizations as well as trying to understand my own psyche and the interplay of forces within it. The following are just a few examples of events and encounters that I have experienced so far:

(1) Picking up the newspaper or listening to the world news continuously confronts me with the destructive conflicts between global spheres or nations or between political, racial, religious or tribal groups and factions mentioned earlier.
(2) Witnessing the struggle, the agony and the frustrations my parents experienced coming from Austria to this country and trying to adjust to a completely new culture and lifestyle.
(3) The trauma I experienced with my marriage breakdown and cutting the ties with the Catholic Church.
(4) My continuous struggle in trying to achieve higher qualifications and the financial, social, and psychological sacrifices that had to be made (and are still being made) in order to reach that goal.
(5) Above all, the profoundest influences have been my experiences in three major organizations - the oil company

with which I worked as a middle manager for several years, the college where I lecture, and the Hospital which has allowed me entry to conduct my research. They are all areas of plurality, change, and power struggles where mini wars, skirmishes and intrigue are the order of the day.

I turned my back on the oil company because my values of personal freedom, security, and job satisfaction clashed with those of the organization which was only interested in competitiveness, profitability and success at all costs, irrespective of human casualties in the process of achieving those goals. Moreover, I witnessed the clashes of powerful individuals in the executive suite and the deviance of ambitious colleagues jockeying for positions to reach the top.

Both the college and the Hospital are battlefields where departments and smaller groups identify other departments and groups as competitors encroaching on their territory or expertise or competing for a budget allocation rather than acting as a team in the achievement of the overall primary task. Any mechanism was used to create a split whether colour, sex, age, occupation, or working on a different floor or geographical location.

In addition, I experienced the deep rooted value differences between the role of the professionals and the bureaucracy within which they work, whether we take the example of the doctor in the hospital or the lecturer in the college. The types of conflicts generated, help to illuminate the contracts between the two systems. In both organizations one finds the professional's resistance to bureaucratic rules, standards, and supervision as well as only conditional loyalty to the organization.

All these encounters and experiences, together with my initial attachment to the local hospital, have combined in some way to my decision in studying and analyzing organizational conflict, especially inter-departmental conflict together with all

the other levels and how they impinge on that central focus. We look at this type of conflict, how it occurs, what are its consequences, and how do we go about preventing it and managing it.

MY USE OF THE LITERATURE ON CONFLICT

Looking through the literature on conflict, I came across many sources which dealt with this topic. Several of these, such as Karl Marx and Ralf Dahrendorf (1959), take a sociological view, dealing with the conflicting nature of society as a whole. The work of Parsons (1964) concerns itself with thoss elements in social structures that assure their maintenace. He views the organization as a fully integrated cooperative system, where members have deeply internalized shared values and the pursuance of common goals. Counteracting power in the system is seen as dangerous and dysfunctional.

Although these writers provided the start for my search, it was not what I believed nor encountered in organization that I knew. Consequently, what caught my eye and kindled my interest were people like Argyris (1957), Gouldner (1955), Cyert and March (1963) and, especially, Crozier (1964). These were the people who strongly reinforced my views about the reality of organizational life and my perception of conflict within enterprises. This was the stream of literature that was relevant and useful to my study of the Hospital, and many of the ideas in it permeate my field work.

What also became clear about the literature up to the mid-1940's was that the early writers saw conflict as unnecessary and destructive and considered that it should be eliminated as it indicates a malfunctioning within the organization. I reject this view, as I also reject the idea that it is management's responsibility to rid the organization of any conflict by applying sound managerial principles. Not all conflict is destructive and can in fact very often be an instrument of change and not an illness. Not only is conflict inevitable in organizations, but it also it can be quite a positive force.

The literature on hospitals as a particular type of organization is extensive. They have been analyzed from a variety of perspectives and have included looking at the hospital from the point of the activities and attitudes of the patient (Cartwright, 1964), or concentrating upon human resources (Argyris, 1956). Other studies have looked at the hospital from the specific vantage point of various participating occupations such as the doctor (Engel, 1969), the administrator (Wilensky, 1964), the nurse (Mauksch, 1966), and various others (Mechanic, 1962).

The topic of conflict in hospitals has received some attention in the literature over the years together with a repeated call of the need for improved understanding and management of it. However up to date relatively little empirical research is available concerning conflict and its management in hospital organizations. Georgopolous (1975) in his review (and source book) of hospital research reported that only a very small percentage of the studies reviewed focused on problems of intraorganizational strain and conflict as the principal area of interest.

Rakich et al (1977) have identified managing organizational conflict as one of three major problems which are of considerable importance to the efficient and effective functioning of the hospital organization. Moreover, they state that

> "the tremendous complex structure of the hospital suggests that the institution is likely to have a fairly high level of conflict among the various participants" (Rakich et al, 1977:179).

Other writers have also suggested that the evidence of conflict in hospitals is not only readily apparent, but also an incredibly serious, unique, and complex issue (Rakich & Darr, 1983; Christman & Counte, 1981; Freidson, 1961): Schulz & Johnson, 1971; Coe, 1970).

According to Christman & Counte (1981:43)
"conflicts over goals, control of personal destiny, incentives, and authority are basic to all hospitals. Each situation, when embellished by human emotions, causes varying reactions in staff members. There are always provocative situations arising that create new strife".

Apart from some of the writers mentioned above, who focus on conflict within the hospital organization overall, most of the literature deals with conflict as it relates to particular health professionals. For example, Ben-David (1958) looked at conflict relating to the role of the doctor in bureaucratic medicine; Bloor and Horobin (1975) studied conflict in doctor/patient interactions; and De Lange (1963) focused on patient role conflict and reactions to hospitalization. A great deal of research, however, tends to concentrate on the study of role conflicts in nursing as for example, Murray (1983), Kramer & Schmalenberg (1976), Corwin (1960), and Benne & Bennis (1959) just to name a few.

The literature was useful on the nature of hospitals, their structure and functioning, and on the part which professionalization and power play within them. The biggest gap was on the issue of conflict, especially since there was little indication of how people faced the conflicts they were in.

TOWARDS A WORKING CONCEPT OF CONFLICT

Dictionaries tend to define conflict with such words as "battle", "clash", "skirmish", "controversy", "collision", "strong disagreement", and "internecine warfare". All these colourful terms are compatible with the idea that conflict arises out of mutual incompatibility. While this idea is adequate for common usage it is useful that we have a deeper understanding of the concept. This is especially so if we are to carry out a sophistcated analyses of conflict in a complex organization such as a hospital.

Words as "battle", "clash", and "collision" refer to major conflict. However, we must not ignore the importance of minor disagreements or frictions which, if persistently maintained, can be as dysfunctional to the organization as a strike or other overt controversy. These minor disagreements can quite easily gather momentum, and if not held in check, they can become a major obstacle, where anxiety, anger, frustration, antagonism, and downright hatred reach such proportions that they result in breakdown between the parties. Once this stage is reached, all sorts of tension and stress will emerge affecting the climate of the whole organization (Green, 1983).

A sampling of the literature provides the following definitions:

> "... a struggle over values and claims to scarce status, power, and resources in which the aims of the opponents are to neutralize, injure, or eliminate their rivals." (Coser, 1956).

> "... that behaviour by organization members which is expended in opposition to other members." (Thompson, 1960).

"... a type of behaviour which occurs when two or more parties are in opposition as in battle as a result of a perceived relative deprivation from the activities of or interacting with another person or group." (Litterer, 1966).

"... overt behaviour arising out of a process in which one unit seeks the advancement of its relationship with the others. This advancement must result from determined action, not fortuitous circumstance." (Schmidt and Kochran, 1972).

"... the process which begins when one party perceives that the other has frustrated or is about to frustrate, some concern of his." (Thomas, 1978).

"... incompatible behaviour between parties whose interests differ." (Brown, 1983).

"...a result of incompatible expectations among people about their relative influence, their desire to protect valued roles, and to maintain a sense of freedom." (Kabanoff, 1985).

These definitions illuminate for me what in the literature is meant by conflict. In spite of the varied terminology, the definitions mean much the same. This gave me a starting point, but did not take me very far.

Clearly, there are various types of conflict, and as I have already mentioned considerable complexity surrounding the phenomenon, particularly in hospitals. I already had noticed from being in the BBH that people were arguing over funds, and had different goals and interests. Personality clashes were evident everywhere. The usefulness of my organizational framework became clearer the longer I stayed in the hospital. From that framework,

it was obvious that conflict is likely to be multi-determined, arising from several sources at once; so that my requirement was not just for a simple definition.

Some further step was necessary. Neverthess, to go forward to a more complex working model of conflict, I still required some definition of my own which though simple and general was enough to carry forward.

Conflict to me is like an inner struggle or being in a bind about decisions or directions. I also see it as incompatible behaviour between parties who want to protect their differing interests, values or goals.

It is not further precision of the definition which will help, but some means of comprehending the complexity of its sources and variety. Considering the variety of conflicts I was seeing, there were some, like gender and professionalization, which were blatantly obvious in some of the conflicts I noticed. The effects of the nurses' strike were also apparent. These issues, however, are issues of the wider society. Other issues which appeared were more specifically to do with the life of this Hospital, such as particular groups who were protecting their own interests or saw their problems from the perspective of their own training.

I therefore made a first distinction between **contextual** features which appear in conflicts, but are not the immediate sources or content of the conflict for the people concerned; and **immediate antecedents** which are those features of the life of the Hospital where conflicts arise. The contextual factors which appear most relevant are health and sickness, professionalization, gender, and industrial relations, all discussed in Part 2. In drawing up the list of contextual factors and immediate antecedents, I drew upon the organizational framework in Figure 1.

Another way of looking at the variety of conflict I was seeing is to distinguish the level at which conflicts are actually manifested. Some individuals are conflicted. Some groups are in conflict with each other, and the hospital itself is also in conflict with other bodies, like the State Government.

The model also reflects several sources in the literature. The notion of levels is fairly common. Some writers listed sources and some have made distinctions between environment and sources. Amongst these are Robbins (1974), Handy (1976), Reitz (1981) and du Brin (1984).

CONTEXT, ANTECEDENTS AND LEVELS

The model comprises

contextual factors which deal with the wider society.

immediate antecedents in the life of the hospital.

levels at which conflicts are manifested.

Table 1. Context, antecedents and levels of conflict

Contextual factors	Immediate antecedents	Levels
health and sickness	task dilemmas	intra-personal
professionalization	differentiation	inter-personal
gender	task dependence	intra-group
industrial relations	organization ambiguities	inter-group
	resource scarcity	inter-organizational
	orientation differences	
	reward system	
	status and power	
	personal characteristics	

As with the organizational framework, the detail of the model in Table 1 has changed since I first drew it up. The version prsented here is more in line with the final position I reached toward the end of the research. I had included role conflict with level of conflict under 'type', but have chosen now to comment later and separately on role conflict. The list of antecedents covers the most commonly quoted sources of conflict, and the types of conflict I had seen in the early stages of my study.

IMMEDIATE ANTECEDENTS

Task dilemmas

As I discussed on pages 7 and 8, the Hospital has a number of tasks namely treatment, training and research as well as a need to attend to its own system management. These separate task emphases may be adopted by separate subsystems, so that issues of balance and priority become group conflicts. Further, differentiated or specialized sub-tasks are carried out by divisions or departments. The operative goals of each subsystem reflect the specific objectives that members are trying to achieve. This differentiation of tasks frequently leads to a conflict of priorities or interests, even when the parties to the conflict agree on the organization's mission or primary task (even on which they may differ as well).

Differentiation

Differentiation and specialization create subsystems which develop significant differences in subculture and behaviour. They possess different structures and respond and attend to different sub-environments of the larger external organizational environment, and their members develop different orientations toward time and toward other people in their interpersonal relations (Lawrence and Lorsch, 1967). There may also be physical barriers to communication which provide the predisposition to conflict, for instance geographic separation and shift work timings.

Task dependence

Task dependence refers to the dependence of one individual or subsystem and another for materials, resources, or information for the successful co-ordination and performance of their respective tasks. Three general classes of task dependence may be discerned: (1) co-dependence (2) sequential dependence, and (3) interdependence

Co-dependence means that two or more units are each dependent on upon a common centre. There is little interaction between units and so conflict between them likely to take the form of rivalry for resources or for support from the centre. Sequential interdependence occurs when the output of one unit goes to the next as on an assembly line. Here the prospects of direct conflict are much greater. Interdependence refers to relatively intense reciprocal relations between the parties in that there is a mutual exchange of materials and information. Sequential dependence and interdependence require the parties to interact frequently, and spend time coordinating and sharing information. If there is disagreement about the issue of coordinating and sharing, conflict can easily be triggered.

Both task dependence and the differentiation of tasks and work activities demand effective communication between individuals and groups. One frequently cited source of conflict is difficulty in communication. This may be as much a symptom of conflict or a means of prosecuting it as it is a source of conflict, for instance the wilful withholding of important information by one party from another in order to attain power. Faults in communication, like ambiguity and distortion as information is passed between units, are likely to be an expression of conflict, but will also reinforce conflict.

Organizational ambiguities

Where there are unclear goals, ambiguously defined work responsibilities, incoherent management systems or status incongruities, conflict is likely to emerge. If one manager tries to expand the role of his or her subunit, this will usually trigger a defensive reaction from the other units involved. Conflict also develops where there is disagreement about who has responsibility for ongoing tasks or where one party tries to take the full credit for success or to avoid the blame for failure in joint activities (Dutton and Walton, 1969).

Resource scarcity

People working in complex organizations are faced with the perpetual struggle of acquiring enough money, manpower, materials, equipment, and space in order to achieve their objectives. Individuals, groups, and organizations can function more smoothly and accomplish goals more easily when these resources are adequate. But because these resources are scarce in most organizations conflict often arises over their allocation (Pondy, 1967; Cochran and White, 1981). There may be agreement on objectives but argument and disagreement on how the resources should be used to attain them, each party claiming a need for a bigger increase or greater share. Many individuals or groups typically believe that they have a legitimate claim on additional resources and try to exercise that claim. The scarcer the supply of resources and the more important the need by the rival parties, the greater the likelihood that conflict will develop and the more intense it will be. Co-dependence upon a central disposing body is the condition for rivalry, since there is little other interaction between parties. Interdependence may be a condition for resource scarcity to be treated as a common problem and handled between the parties.

Apart from the need for vital resources, they also symbolize power within the organization and outside. The ability to obtain and own resources enhances prestige and influence.

Orientation differences

The fact that we interpret reality differently seems to be a natural by-product of specialization. It is also influenced not only by the unique demands of the external environment that must be managed, but by the other organizational processes, such as selection and placement, specialized training and development, education, career aspirations, and different unit performance criteria and reward systems (Miles, 1980). Semantic difficulties may arise from the different training, background and orientation

of people in different units (Strauss, 1962).

Examples of this basic phenomenon are clashes between different functional departments, union versus management, and professionals at odds with the bureaucracy either as groups or individuals (Sofer, 1972).

Reward system

The reward system can govern the degree to which individuals and subunits co-operate or conflict with one another (Walton and Dutton, 1969). If jobs are interdependent and the success of one party which is better off than the one it is partly dependent on for co-operation, conflict may result. Problems also arise if low performers receive as many rewards as high performers.

Status and power differences

Status differences provide a basis for conflict, especially when actual working relations do not correspond to perceived power. This occurs when individuals or departments with less power try to tell other individuals and departments with more power what to do (Seiler, 1963; Whyte, 1948). Conflict is also likely when one department tries to improve its status and other departments perceive this to be a threat to their position in the status hierarchy. This happens quite frequently between line and staff personnel (Dalton, 1959) or between different professional groups. Units of lower status sometimes struggle to dampen or reverse the direction of initiation by higher status units or personnel.

Personal characteristics

So far I have been talking about structural factors that tend to predispose conflict. However, interpersonal skills and the personality of representatives of the interacting subunits also influence co-operation between the units as well as relations

within each unit. Personality traits and communication skills are important factors in shaping the direction and intensity of interunit relations. Prejudice, ambition, or lack of behavioural skills generally, may jeopardize harmonious interaction by provoking hostility and resentment on the part of the other parties. Dalton (1959), for example, found that personal differences such as age, education, background, attitudes, and behaviour patterns lowered the probability of interpersonal rapport between unit representatives thereby limiting co-operation on the part of each unit.

Leadership style can also have a powerful effect on the degree of conflict in a group. For example, an autocratic, dominating, dogmatic, or demeaning behaviour by a formal leader can be very detrimental to group cohesiveness and morale. It can also cause friction where members have a strong need for independence and autonomy.

LEVELS

Conflict within the individual (intrapersonal conflict).

This involves psychological conflict or discord occuring within a person. It is a struggle among incompatible or differing values, beliefs, allegiances or choices. Intrapersonal conflict will often influence how an individual responds to, or influences, other higher level types of conflict. Examples of this type are conflict between two ethical principles or beliefs, uncertainty as to what work is to be performed, or when work demands conflict with other demands.

Conflict between individuals (interpersonal conflict).

This type of conflict focuses on interaction patterns and behaviour between two or more individuals caused by personality differences, role-related pressures, or cultural group values. I will discuss role conflict more fully below.

Conflict within groups (intragroup conflict).

Frequently this is related to the way individuals deal with the pressures imposed on them by their work group. For example, a person's desire to satisfy affiliative or esteem needs through their group, but member demand conformity or undesirable behaviour.

Conflict between groups in the same organization (intergroup conflict).

This type of conflict is the expressed struggle between at least two interdependent social system such as labour-management groups, functional departments, professional groups, or staff-line departments.

Conflict between organizations.

These conflicts may be larger and more complex than conflicts within organizations. The parties to the conflict are the organizations represented by departments or through individuals occupying boundary roles. The survival of one or both organizations may be at stake relating to critical resources or vital information.

ROLE CONFLICT

Role conflict enjoys a large literature. The thesis is not conceived in terms of role conflict, but there are notions which are commonly quoted, and which have proved useful from time to time. They relate not solely to one specific level of conflict, but rather to some aspects of the structure of conflicts. I think it is important to note them.

A role is a set of activities or expected behaviours associated with a particular job or position in an organization. Role conflict occurs when two or more incompatible demands or pressure are placed on an individual. The intensity of the role conflict depends on the strength of the role pressures and the focal person's ability to handle that pressure. There are four basic types of role conflict that are fairly common in organizations: intrasender conflict, intersender conflict, inter-role conflict, and person-role conflict (Katz and Kahn, 1966; Kahn et al, 1964).

Intrasender role conflict. This occurs when there is one role sender from the role set who presents separate required job behaviours or expectations to the jobholder that are incompatible with one another. For example, the supervisor may pressure the subordinate for quantity and quality when the two are inconsistent with each other.

Intersender role conflict. This arises when orders or expectations from one person or group clash with the orders or expectations from other persons or groups. In this case, there are pressures on an individual from many directions or the various senders attempt to influence his or her behaviour. An individual, for example, who finds himself or herself under a dual-hierarchy authority (professional and bureaucratic) will experience this type of role conflict.

Inter-role conflict. This kind of conflict arises when the different roles played by the same person give rise to conflicting demands. Such a possibility happens quite frequently as we all have multiple roles to play. An individual may be an employee in an organization, a husband, a father or a union representative. Each role is associated with different expectations from the members of each role set. Frequently, these differing roles make conflicting demands on the focal person. Developing a system of trade-offs or compromise can assist in overcoming the conflict.

Person-role conflict. This occurs when incompatibilities arise between the pressures of the person's role(s) and his or her own needs, attitudes, values, or abilities. Pressures may be put on an individual to behave in a certain way which are opposed by his or her personal code of ethics. This type of conflict is generated directly by a combination of externally sent role expectations and internal forces.

From these four basic types of conflict other complex forms of conflict may develop. These are role overload and role ambiguity.

Role overload. This happens when the individual is confronted with the sent expectations from a number of sources that cannot be completed within the stipulated time and quality limits. Dilemmas such as task priority and time versus quality

are some of the pressures that are then put on the individual.

Role ambiguity. When an individual is provided with insufficient or unclear information about his or her responsibilities there is uncertainty about what to do. The greater the experienced ambiguity, the more the individual experiences tension and anxiety. Certain information is required for adequate role performance so as to conform to the role expectations held by members of the role set.

Role conflicts are often minor and the resulting tensions may even lead to greater innovation and individual development. Intense role conflicts, on the other hand, can have adverse effects for the individual and the organization. People who are in intense role conflict situations over a period of time often experience high levels of job-related stress, dissatisfaction, tension, low morale, and a negative attitude towards the organization.

INTERACTION BETWEEN LEVELS

Separating the various levels of conflict, we can analyze the situation where conflict is taking place at more than one level at a particular moment. The fact that there is turmoil inside the individual may quite easily influence his or her behaviour at the higher level where there is a clash with another individual or group. Consequently, we have several levels. At one level there is a theoretical or conceptual point of correspondence in that we have some sort of incompatible direction of forces which is different to one's own internal psychological conflict. This is also different from the warfare and competition between people over scarce resources or different values and so on.

Individuals are faced with alternative pulls over which they have to make compromises which play into the kind of conflict we find within the groups. Groups or subunits collide over different reasons. One of the problems they may have or one of the things that is curious about it, is what the relation is between their competing with other groups and what they are doing about the conflict within the group. We often find that the group that is the most competing outside is the group that is internally highly conflicted. The most rigid and difficult groups to deal with in negotiation are those which have discord that they cannot confront because they dare not break the internal collusion.

Because the individuals in the group are themselves conflicted, which is at the one level (interpersonal conflict) but at the group level becomes the intra kind of conflict (intragroup conflict). The group is internal conflict in the same that the individual is in internal conflict. So, structurally we can look at what happens in a group either way. If we want to understand the conflict between the groups (intergroup conflict) we must look at what is going on inside each group (intragroup conflict). If we want to understand the conflict between individuals in a group we get a better picture if we know what is going on within the various actors which is causing them to behave that way. But at each level it is a different question.

A subunit, therefore, may be embattled with others as a result of the intragroup conflict that is going on. This again, if we look at it, could be due to a conflict between significant and powerful people in the group because they themselves are internally conflicted. They are holding the group locked or fixing the group in such a way that the group is then at war with others in the organization.

The focus of the thesis is on intergroup conflict within the Hospital. That leads to the question of what we can see at that level and to what extent we need to go higher or lower, as far as the levels are concerned, to understand what we see. It is only by exploring or prodding that one is able to detect where the problem is. Conflict is replicated at every level from the individual to the group, to the subunit, and from there to the complex organization and to the society. In addition, at every level there is both intra conflict as well as inter conflict which provides plenty of room for concealment of the exact nature of the causation of the manifest conflict. For instance, collective blaming of an individual may conceal an intergroup conflict, or a powerful but conficted individual may 'export' the conflict to a group which in turn may engage in conflict with others.

RESOLUTION OR MANAGEMENT

The bigger the organization becomes and the more complex its structure, the more opportunities there will be for conflict to erupt. In addition, the greater the degree of interdependence within and between organizations, the greater the need for more effective conflict management.

If there is commitment and identification with the task there will surely be conflict because there is more than one task. It is inevitable that where there is group cohesion there will be group conflict. The issue of removing or resolving conflict does not apply to a situation where people are in conflict because everybody is committed and thinking. If no one is conflicted about anything, nobody is dedicated or gives a damn about anything.

The price of initiating changes is often to produce conflict, which can be regarded as constructive. Successful conflict management lies between minimizing the destructive forces without interfering too much with the creative side effects.

It seems to me that the means of management of conflict are rather complex. For a start, understanding the immediate antecedents helps one to address the conflict. Moreover it is important to decide whether the conflict is constructive or destructive.

Changing the antecedents

One way to address conflict is to try to change the antecedents, if that is possible.

For instance, one may be able to overcome goal incompatibily by establishing meaningful positive superordinate goals. This, however, can prove to be difficult, especially in such a complex

organization as a hospital. Conflicts arising from organizational ambiguities and task differentiation would demand restructuring. Expanding resources to reduce internal conflicts transfers the conflict to the relations between the organization and its environment.

Changing the way conflicts are handled

Another way of managing conflict is to try to change the way that people are handling it. A lot of the literature on conflict management addresses this issue, rather than with the changing of antecedents. There are exceptions. Brown (1983), for instance, looks to some extent at strategies of both types.

Most texts on conflict present a list of strategies much like the following, for example Blake and Mouton (1978), Thomas (1976) and Robbins (1978).

Avoidance. One method of dealing with conflict is to withdraw from it or remain neutral by refusing to be drawn into openly expressing any feelings or differences. Tactics for achieving avoidance could be leaving the conflict situation, denying that conflict is taking place or postponing the issue. The danger is falling in a rut of complacency.

While it may not bring any long-run benefits, it is an extremely popular short-run solution. It can be a useful technique, for cooling off the parties or preventing disputes about unimportant matters. However, the conflict itself is not effectively resolved, nor is it eliminated, leaving most of the people involved dissatisfied.

Smoothing. This style is a more diplomatic way of suppressing conflict by the intervening person. Smoothing platitudes are offered. In this way, differences between the parties are played down and common interests are emphasized leaving the real issues

unresolved. The conflict frequently resurfaces later because problems that will not go away are ignored. Smoothing is particularly important when the preservation of relations is more important than dealing with the conflicting issue. If the differences between the individuals or the groups are serious, smoothing, like avoidance, is at best a temporary short-term solution.

Forcing. This is a conflict-resolution strategy in which one party uses its superior power to impose its conflict solution on the other party. Power can come from a person holding formal authority; from persuasive cohesive parties; or from majority rule, as in voting. Whatever the source, the outcome is either winners or losers. Forcing is useful when a quick or unpopular decision has to be made or issues critical to the organization's welfare need to be implemented. Because this type of strategy does not bring about agreement between both parties, the conflict remains unresolved often leaving bitter resentment, lack of co-operation and commitment to the solution, along with efforts to retaliate.

Compromise. Compromise techniques, which are "political" tools, make up a major portion of resolution methods. Compromise involves settling differences in which each side make concessions through the process of bargaining and negotiating in order to achieve a workable solution. The outcome of the bargaining itself depends to some extent on the balance of power between the parties. Compromise leaves no clear winner and often fails to reach the solution that will best help the organization achieve its goals. However, at least it offers some degree of satisfaction and partial fulfillment of the needs of each party so that they are less likely to feel latent hostility. In addition, this method can be useful for the following reasons: when settling an immediate issue; to forestall a win-lose outcome; when resources are limited; and when other conflict resolution strategies are not successful.

Integrative problem solving. This is a constructive process in which the parties involved recognize that conflict exists and openly try to solve the problem that has arisen between them. That is, intergroup conflict is converted into a joint problem-solving situation where all members and groups involved in the conflict work together. The aim is to achieve a common goal in an atmosphere of open and free exchange of ideas, stressing the benefits of finding the best solution.

Although integrative problem solving has great potential, it requires (1) a clear definition of values and goals; (2) open and honest communication of facts and feelings; (3) a sense of responsibility of all who participate; and (4) an environment of trust and commitment of all to the success of the process. These conditions are very difficult to achieve. Thus, although it is in many ways the best method, even though it may not guarantee to provide an optimal solution, there are situations in which the other means are more practical.

My reason for examining these means of conflict management or conflict resolution (which as Robbins, 1978, points out are not synonymous) was an interest in whether or not any of these were being used in the Hospital, or could be used, and whether or not I might help by pointing our some of the available methods.

The approach I have developed in this Part of the thesis gave me frameworks which have enabled me to grasp some of the complexity which I was facing, and, as we shall see, the intractibility of much of the conflict and the resistance to a 'rational' approach to conflict management.

PART II

HEALTH CARE

CHAPTER 4
THE HEALTH CARE ENVIRONMENT

It is becoming increasingly obvious that the environmental context in which hospitals exist in Australia are undergoing change at an increasing rate and are often characterized by turbulence. This change and turbulence in the environment is due to the development of scientific knowledge, changes in professions, tightening of government funding, scarcity of resources, and a change in societal values and attitudes. Such a changing, turbulent, and uncertain environment is a conflict producing environment.

The health of the community is determined by various environmental factors or inputs, namely personal, community, environmental, and the health care services (Dewdney, 1972). All these factors relate to and affect one another to produce the complex psychosocial (emotional and mental) and somatic (physical) health or well-being of individuals in the community.

Apart from the well-being aspect, we are also at the same time focusing on a portion of the general environment which is important in explaining the structure and functions of hospitals within it.

1. Personal and behavioural determinants of health

Heredity or genetic endowment (which determines race, sex, phsycial and mental potential for development) is recognized as having a major influence on susceptibility to disease and the inheritance of disease; age composition of the community, especially those over 65 years or more; experience of illness and injury; individuals educational levels and occupation; and the effects of affluence and poverty.

Behavioural determinants relate to personal behaviour and habits such as drinking, smoking, abuse of drugs, sexual permissiveness, dangerous driving, overeating, neglect of personal hygiene, and delay in seeking medical care.

2. Community determinants of health

Socio-cultural factors such as beliefs, values, norms, customs, traditions, and personal habits are vital inputs to health. Other determinants under this category comprise population characteristics; the distribution of community resources; religious organizations; the pattern of agriculture and industrialization; the degree of urbanization; and the role of political organizations at the federal, state, and local levels.

3. Environmental determinants of health

These embrace the natural physical characteristics of the environment such as climate, soil conditions, vegetation, the atmosphere, water, and phsycial geography. Moreover, it also includes man-made aspects of the environment such as housing, transportation, communication, sanitation, and the work environment.

4. The health care system

Health care services comprise various different instrument alities and institutions including the community health services delivered and the various public health agencies provided by government. The next section outlines the major features of the organization structures of the centralized health service of the governments of the Commonwealth and the States. The diversity of these organizational structures provide the framework through which these governments deliver health services.

THE HEALTH CARE SYSTEM AND HOSPITALS

Apart from the various governmental instrumentalities and agencies, the health care system comprises a complex hospital industry which forms its major component. Hospitals are clearly the dominant single organizational unit for the provision of health services measured by the amount spent on them by governments. This hospital system includes those hospitals that are wholly provided for by the respective States; hospitals partially subsidized by the State or by State endowments; private hospitals conducted commercially; public and private nursing homes; mental hospitals maintained by the respective States; and repatriation hospitals maintained by the Commonwealth Government.

In the State of Victoria in June 1985 there were 166 public hospitals providing 15,360 beds compared to 117 private hospitals with 5,951 beds (Grant and Lapsley, 1985).

Types of public hospitals

There are certain basic differences in the types of public hospitals which exist between and within societies. Two types of distinctions can be made. The first involves the amount of specialization concerning itself with the types or categories of patient that a particular hospital caters for. The second concerns differences in the size of a hospital and its impact upon internal specialization.

1. Functional specialization. The main distinction to be made is that between General Hospitals and those that are functionally specialized. General Hospitals deal with all or most kinds of disease found in the population. This is reflected in their structure and operations by providing facilities and doctors in all the main specialities of medicine (e.g. General Medicine, General Surgery, Dermatology, Orthopaedic Surgery, E.N.T.

Surgery, Gynaecology, Obstetrics, Paediatrics, Geriatrics, Urology, Psychiatry, etc.). These kinds of hospitals serve and relate to a particular community by meeting whatever medical problems arise within that community.

Functionally specialized hospitals, on the other hand, deal only with particular kinds of patient and disease. The following are the main types of functionally specialized hospitals: Geritric Hospitals, Psychiatric Hospitals, Maternity Hospitals, Children's Hospitals, and Infectious Disease Hospitals.

Another functional distinction which overlaps the two previous categories relates to teaching hospitals. Most teaching takes place in larger general hospitals but is not uncommon in larger specailized hospitals as well.

2. Size and internal specialization. The public hospital sector can also be categorized by a hierarchical structure according to size or technological complexity. At the lower rung are the smaller rural general hospitals, offering basic in-patient, out-patient and accident and emergency services to their communities. Patients requiring a more intensive or complex level of health care are usually referred to Base Hospitals in the larger centres. Here, a greater variety of more specialized skills and technology is available. At the highest rung are the larger general and specialist teaching hospitals found in the metropolitan area.

These various health care institutions form the backbone of the health care system within which they are embedded. Thus like all formal organizations they do not exist in a vacuum but are open systems that are constantly influencing and being influenced by their environment. A hospital's external environment has a pervasive influence on its internal system, affecting many aspects of its tasks, technology, structure, and interpersonal relations.

In order to analyze the dynamic workings of a hospital we need to focus on the community or task environment. That is, the task environment is specifically limited to the particular community within which a hospital is located and those characteristics that affect its culture. Although the task environment usually extends beyond the bounds of the local community, the discussion will also include the broader community.

HISTORICAL DEVELOPMENT OF HOSPITALS

To understand modern general hospitals, including the BBH, it is necessary to provide a brief historical perspective which provide insight into some of their unique organizational features. The development of hospitals proceeded in pace with the prevailing needs, values, beliefs, and attitudes of the societies they served. The current structure, functions and controlling elite reflects forces involved in the historical development from the eighteenth century on. Various structural changes have occurred which have influenced hospitals as social systems.

Eighteenth and Nineteenth Centuries

During this period hospitals were established as independent institutions managed by a board of trustees and frequently funded by a rich benefactor or the community. Institutional survival depended on private contributions and so the most important task of a hospital was the procurement of resources. Consequently, donors or their community representatives (trustees) exerted great power. On the other hand, administrators and medical personnel had little power or responsibility. Doctors worked independently using the hospital as a training ground. This early detachment of the medical staff from the hospital provided the basis for the continued separation of the board of trustees and the administrator from the medical staff. This dual hierarchy remains as one of the unique characteristics of the modern general hospital creating a great deal of conflict and power play.

Twentieth Century

Whether viewed as developmental stages of hospital organization or as a conflict process, several drastic shifts of power could be witnessed within the hospital during this period. First the trustees' domination was replaced by medical

domination, which was then followed by administrative power, finally reaching a stage of political maneuvering or multiple domination (Perrow, 1961, 1963).

Medical domination. The rise of scientific medicine and the dramatic developments in medical technology during the first half of the century revolutionized the functions and role of the hospital. It became a primary institution for treatment; a destination for the ill of diverse ailments and social standings. Moreover, at this time, the value of the hospital as an educational institution for doctors, students, and nurses was increasingly recognized. As medicine was put on a firm scientific basis and doctors monopolized the skills to utilize these scientific advances, their status and power increased dramatically in the authority structure of the hospital. Not only did the doctors acquire functional power but by bringing in private patients, they also began to play a financial role in the hospital and thus demand a greater say in hospital operations. The hospital became a necessary resource for the pursuit of the doctor's economic interest which, of course, it still is today.

The legal power of trustees became nominal and administrators saw themselves more in the role of "housekeeper". Neither one was considered qualified to consult on operative goals and policy matters.

Administrative domination. The administrator rose to power because, as hospitals became large and complex someone with knowledge and skill in administrative matters was needed to co-ordinate the numerous non-routinizable functions. Also, health services became so interdependent that the co-ordination of the hospital and other institutions (e.g. hospitals, welfare agencies, Governmental bodies) as well as the community became important. The administrator was in a position to influence

internal affairs of the hospital through manipulating external relations (Perrow, 1961). The operative goal or orientation of the administrator tended to be (and still are) toward financial solvency, efficiency, careful budget control, and minimal development of services.

Although the power of the administrator had increased a great deal, the importance of the doctor and the hospital's dependency on him had not declined. They could still demand a say in major policy formulation. Only the trustees seemed to have lost much of their status and influence.

Multiple domination. The general hospital of today such as the BBH has become a most complex organization with new, multiple and evolving goals. It is characterized by advanced technology, the employment of a large number of professionals, and a high degree of specialization of labour. Every component of the system tends to fulfill some vital or important function. Because of functional interdependence and indispensability, power is usually shared by three stable known centres. This is a triad type arrangement including the governing authority, chief executive officer or executive team and the medical staff, together with the ever increasing influence of the nursing division. Although this arrangement permits a sharing of power among the various parties it can best be described as a shaky conflictive power equilibrium.

ORGANIZATIONAL FEATURES OF HOSPITALS

Every hospital is unique in its culture including the BBH. However, it is also a fact, that some organizations, like a hospital, are more or less alike so that we can make generalizations about them. The very word "hospital" implied that all these organizations have broadly similar missions, tasks, technologies, and social structures. We are looking at a recognized cultural model which is the outgrowth of a tradition (Coe, 1970).

Hospitals share certain characteristics of all larger work organizations as reflected in Max Weber's (classical) model of bureaucracy. It is by and large bureaucratic in form with a division of labour that is based on functional specialization. This, in turn, provides the organization with a specialized body of knowledge (gained from specialized training) and a specificity of expertise. In addition, the hospital has a system of codified rules and procedures covering the rights and duties of all those workings within the establishment which enables a certain degree of standardization to take place. There are also defined channels and procedures of communication in use. Finally, the hospital characterized also by a prestige system. Every individual and sub-group has an achieved (rather than ascribed) status.

Apart from the characteristics common to other working organizations, hospitals have certain features which deviate from the Weberian model, giving uniqueness to its activities. Listed below are the main distinguishing organizational features of hospitals according to Georgopolous and Mann (1962); Wilson (1965); Georgopolous (1972), and Rakich and Darr (1983):

Multiple tasks. Although the primary task of the hospital is to render personalized care and professional treatment to patients, there are additional major tasks to attain such as teaching and training for doctors, nurses, and other personnel as well as research. Moreover, there is also a diversity of tasks for different sub-systems, professional groups and individuals themselves which are sometimes alternating with each other or operating simultaneously but tending in contradictory or conflicting directions.

Strong link to the community. Hospitals unlike industrial organizations, for example, it is much more directly dependent upon, and responsive to, its surrounding task environment.

Nature of the task. Because the hospital renders professional individualized care and treatment twenty-four hours a day, the nature and volume of work is variable and diverse which makes it very difficult to set meaningful and measurable goals. The end products are human and participate in the production process and often try to gain a certain degree of control over it. In addition, the tasks are frequently of an emergency nature and non-deferable which places a great burden of both functional and moral responsibility upon the hospital and its staff causing a great deal of anxiety and stress.

Multiple authority. One of the features of hospital organization is the presence of multiple lines of authority. In the BBH and may other Australian hospitals there is is a multiple authority system consisting of the Chief Executive who is responsible for the administrative services, the Director of Nursing in charge of the nursing service, and the Medical Superintendent responsible for the resident medical staff and the paramedical and ancillary professions. The visiting medical staff are independent

contractors over whom the hospital has no line authority. The Chief Executive Officer delegates to his lieutenants in the administration sections, but although he is nominally in charge, he relates to the other two senior managers on a negotiating basis. That is where most of the conflict emerges.

By comparison with industrial organizations, hospitals have relatively little control over their work load and over some of the key members, especially doctors and patients - two of its most essential components. Most of the medical staff are not employees and yet control the clinical decision-making process. Moreover, their professional norms are enforced by collegial authority or peer review (Hause, 1970). Patients, on the other hand, are not only a very transient and heterogeneous group, but are also, mainly and ultimately, in the hands of their doctors (Georgopolous and Mann, 1962). In addition, health professionals, especially doctors, are socialized to a form of rational, specialized, autonomous, and expert behaviour. They place value on personal achievement, autonomous decision-making, and the importance of improving their own performance rather than that of the hospital. The rewards of reputation and respect may come more from their affiliation outside than from within the hospital.

What seems to be lacking in many hospitals is some form of "coherent, identifiable and responsible" management (Hutton, 1962). Hutton argues that in most other enterprises general management is vested in an individual or a group. As he points out: "The same people are the material on which the hospital operates, the consumers of the hospital's services and the owners of the hospital. The implication is there needs to be a clear focus of responsibility, an agency to coordinate and to regulate the diversified internal activities of the hospital, and to mediate its relations with its environment - to speak for it and represent it from a basis of responsibility." The senior personnel involved in the decision-making process are not on an equal footing and do not all act in a general management capacity.

Diversity of personnel. Another feature of hospitals is the elaborate division of labour and specialization. Focusing on a typical nursing unit or ward provides a microscopic view of this diversity of personnel. Within the hospital, people of very unlike backgrounds and rank with different skills, values, needs, attitudes and orientations are interacting within a work structure which requires a high degree of functional interdependence and loose co-operation. In such a complicated web of interaction the existence of conflicts is inevitable. Many of these conflicts persist but the fact that the system can contain and resolve numerous others to the extent that it does, is an important result of member adjustment, psychological commitment, and voluntary co-operation.

Although attitudes are changing towards greater self-interest, there still remains an ideological commitment to patient care. That is, "vocational" elements play a major role in the motivation of many members (Sofer, 1955). This is in line with Etzioni's (1961) categorization of hospitals as normative organizations and Crozier's conflictive power equilibrium. Under this category individual members tend to co-operate on the basis of high motivational and moral involvement.

GOVERNMENTAL ORGANIZATIONS

Modern hospitals of today like the BBH exist in a very demanding and complex environment. Important issues and problems of recent years have strongly influenced the operation and management of these hospitals. They include the re-organizing and re-equipping of existing hospitals with the latest clinical technologies and computerization; the continuing escalation of hospital costs coupled with increasing levels of population; the continuing problem of the nursing shortage; the rise in the waiting lists for hospital beds and surgery; the continuing organized consumer interest in hospital functions and services provided; and the industrial unrest culminating in members of the Royal Australian Nursing Federation (RANF) going on strike.

The Government's expanding role in hospitals has been a major feature of the past several decades. Governments at all three levels - Commonwealth (Federal), State and Local Authorities - carry a heavy responsibility for the provision and operation of health care services. Through their roles as providers, regulators, and financers they have a major influence on the management and operation of Australian hospitals. Hospitals and Government are thus closely linked in many and complex ways. Public hospitals are funded by the State government, but funding depends upon the amount of money allocated to the States by the Federal Government.

The Commonwealth Government

The principal health agency of the Federal Government is the Commonwealth Department of Health. This is a specialist body concerned with the planning and development of a range of national policies including the universal health insurance system, Medicare, with the provision of certain specialized scientific services, and with authorizing the payment of Commonwealth hospital grants and subsidies under the National

Health Act. Other departments are the Commonwealth Department of Community Services and the Department of Veteran's Affairs - Repatriation Commission.

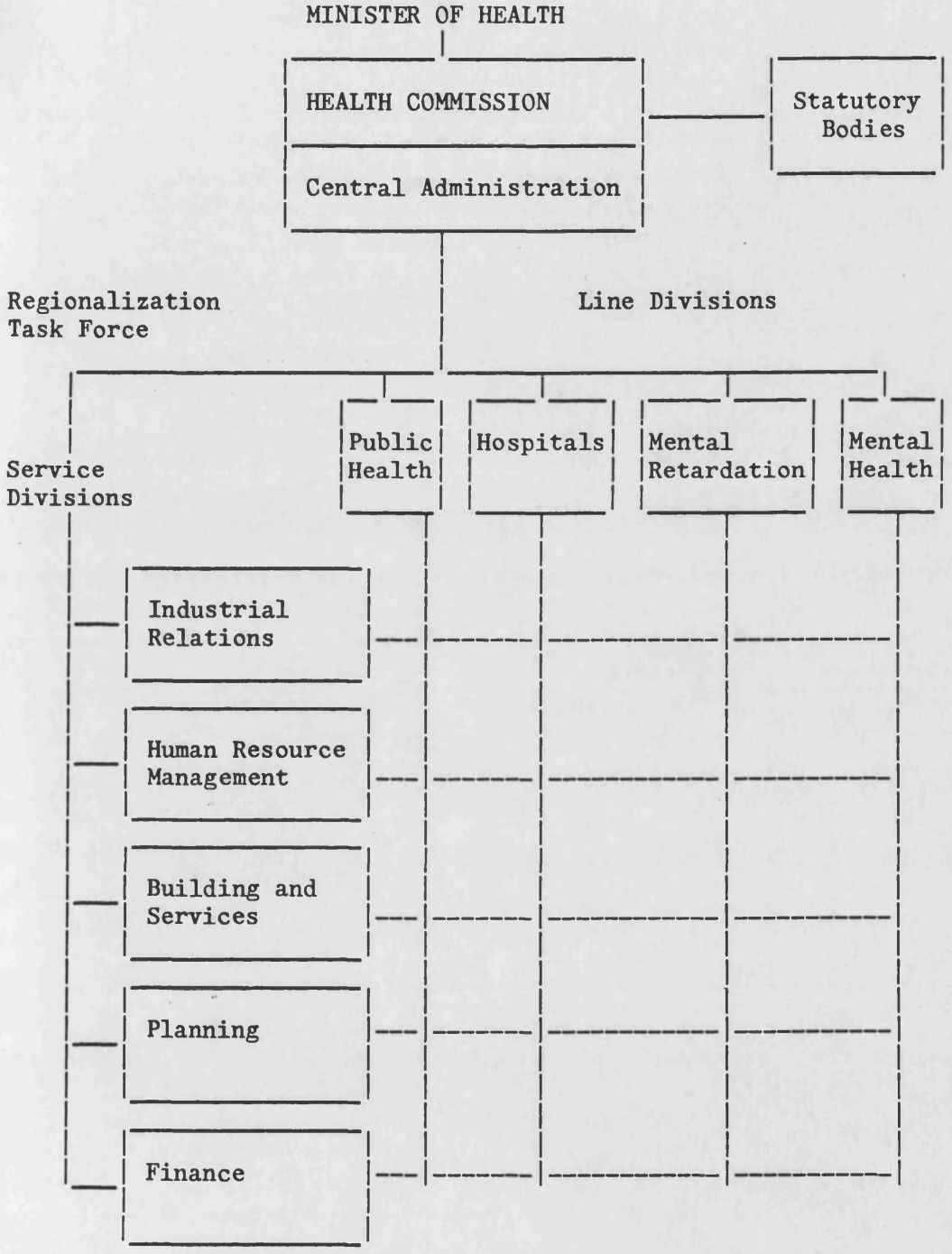
The State Government of Victoria - Health Department and Commission

The responsibility for public hospitals is in the hands of the State governments. From December 1978, the State's health services have been the responsibility of the Health Commission which is the statutory body responsible for the oversight, supervision, maintenance and co-ordination of health services in Victoria. This major objective is implemented through the provision of health services both by the Commission itself (e.g. Mental Health Services) and indirectly through public hospitals and community health centres and other functions. It's function is to implement the policies of Government and to discharge the obligations under the Acts for which the Minister for Health and the Commission are responsible.

As indicated in Figure 3, the major responsibilities of the Commission's operating divisions are the Hospitals Division, the Mental Health Division, the Mental Retardation Division, and the Public Health Division. These are supported by appropriate service divisions such as planning, finance, industrial relations, human resource management, and buildings and services (Health Commission of Victoria Annual Report 1984/1985).

In addition, with the implementation of regionalization, three metropolitan and five country regions have been established, each represented by a Regional Director. The aim of regionalization was to replace the existing centralized structure with the eight smaller and less complex regional administrations to control and co-ordinate health services. This, it is hoped, should improve the capacity of the Department/Commission to respond to community health needs and to implement Government policies.

Figure 3: Health Commission of Victoria



Source: Health Commission of Victoria, Annual Report 1984-85 VGP December 1985, pp. 131-135b.

State government control mechanisms

Although public general hospitals enjoy a certain degree of independence or autonomy in their decision-making, the State's control mechanisms have grown and become increasingly rigorous in their application. The control mechanisms cover most financial matters, buildings development, clinical services planning, aspects of hospital staffing, appointment of hospital Boards, the approval of hospital by-laws, powers of direction and inspection under State legislation, and the establishment of regional administrations (Grant, 1985).

Financial controls. Hospital costs have continued to escalate, with corresponding demands for more funds in order to meet operating costs and capital expenditures. The Health Department-Commission is concerned to ensure that these operating costs are kept within reasonable limits. It is up to the individual hospital to function efficiently and economically.

Most hospitals cannot pay their way without substantial Government support. Thus, financial aid to hospitals carries with it the need for a great deal of Government direction and supervision in the financial and administrative affairs of public hospitals. The essential problem of hospitals is one of finance. Hospitals are heavily dependent on Government subsidies to supplement their income from patients' fees in order to meet their operating and capital expenditures.

Staffing. One of the more specific government influences over staffing matters in hospitals is the approval of the appointment of senior executives such as the Chief Executive Officer, the Medical Superintendent and the Director of Nursing. In Victoria, the Chief Executive Officer is appointed by a hospital Board, subject to the approval of the Department.

Appointment of Boards. When a vacancy exists it is advertised and recommendations from the Board and other influential members of the community are given to the Minister. In turn the Minister decides who should fill the vacancies and forwards his decision on to the Chairman of the Board.

Hospital By-laws. Hospitals are empowered by the major hospitals act to draw up by-laws which are the internal legislation or rules governing the operations of a hospital. They are normally subject to the approval of the State hospital authority and thus represents another, if minor, source of control.

Regional Administration. Although the power and the directives come from head office, regionalization offers the potential of closer Government control and influence. Depending on how this is utilized it can facilitate the monitoring and regulating of hospital activities and conformity with government regulations and policy.

NON-GOVERNMENTAL ORGANIZATIONS

Other organizations in the environment, apart from Governmental bodies, are also major sources of influence on a hospital's operation and management. Some of these organizations are large in number and diverse in nature, exerting influence in various ways.

1. Professional associations

The major national bodies relevant to hospitals are the Royal Australian College of Surgeons (RACS), the Australian College of Health Service Administrators (ACHSA), the Australian Medical Association (AMA), and the Royal Australian College of Medical Administrators (RACMA).

The RACS is an educational body for doctors wishing to qualify in a particular speciality. This means an extra 6 years of training in a hospital which is accredited by the RACS for that purpose. The progression is from junior resident to registrar and then finally to a full qualified specialist.

The ACHSA's major aim is to improve the quality of health care by such activities as developing and promoting more efficient organizational forms and educational programs. It has had some success in limiting the appointment of "unqualified" persons to senior hospital administrative positions. The RACMA provides post-basic vocational training and some continuing educ tion activities.

The AMA is a large institution covering many diverse individ uals and groups. However, its two main aims are the development of health care through the contribution of the medical and allied services, and to promote, maintain and extend the honour and interests of the medical profession (AMA 1985 Annual Report). The latter involves the issue of professional self-determination and

autonomy versus bureaucratic demands and, above all, the AMA's preference for private medical practice reflected in private health insurance and in the fee-for-service payment mechanism.

2. The hospital unions

Most hospital employees belong to either the "Hospital Employees Federation" (HEF) or to the "Royal Australian Nursing Federation" (RANF). The HEF covers a wide range of skilled to unskilled personnel including administrative and clerical staff, catering and domestic people, technical staff, hospital orderlies, nursing aides and others. Over the years there have been several rolling stop work meetings in support of wage rises, and cut backs in government funding have also caused problems with staff shortages. The impact of this union on the BBH has been the promotion of member's interests through securing award determinations for their terms and conditions of service.

It is only in the last few years that the RANF has become more influential and effective in securing favourable terms and conditions for its members. When organizing for collective bargaining, registered nurses tend to seek the economic and general welfare arm of the RANF. The Federation covers all qualified nursing personnel throughout Australia and students taking a programme leading to a nursing qualification. Membership stands at around 38,000 with the Victorian Branch being the largest with over 15,000 members. The numbers are increasing due to a growing awareness among nurses as to the advantages of having a national body coupled with a growing interest in political and industrial issues. Interpretations of conditions of employment, disputed payments and conflict in the area of patient care were seen by the membership as the main areas of contention over the last few years.

3. Educational institutions

Those which have the greatest effect on hospitals are the universities, the tertiary colleges and the Royal Colleges of various medical specialties which were already mentioned under Professional Associations. Their main impact upon hospitals is achieved by their effects on the volume of supply of potential professional staff and by determining the level and the nature of skills, knowledge, values and attitudes offered.

4. Voluntary agencies and associations

There is quite a variety of these organizations but those of particular relevance to hospitals are the provider groups and consumer groups. The provider groups are the ones that have the closest contact with hospital, and thus the greatest impact. The Australian Hospitals Association (AHA) is involved in educational activities especially for hospital Board members and has joined with the AMA to establish the Australian Council on Hospital Standards (ACHS). The State hospital associations such as the Victorian Hospitals' Association (VHA) is the major purchasing agency for Victorian public hospitals and related bodies as well as providing advisory, research and educational services for its members. The ACHS aims to promote and encourage the best possible quality of health care through the conduct of the Hospitals' Accreditation Programme. As the level of standards becomes more rigorous so the direct impact of ACHS increases.

Consumer groups, such as the Medical Consumers Association, show a general concern for patients' rights. However, their impact on the running of hospitals is minimal because the force that unites the group does not embrace all potential patients.

CHAPTER 5
THE HEALTH PROFESSIONS

OCCUPATIONS AND PROFESSIONS

Occupational specialization in the health field is increasing rather rapidly due to the growing number of persons in the professional category and the growing number of occupations which have become professions. This increase is creating numerous problems of conflict and accommodation.

A complex organization like a hospital, for example, is one of the primary means in our society for the specialization and utilization of skill and knowledge. An input of professionals into a hospital means importing groups and sub-groups with their own culture and strong sense of identification. Each group of professionals will have had a common educational experience through which the individual has been carefully trained not only in the skills and knowledge of his or her profession but has also been exposed to a set of values, beliefs, sensitivities, and orientations to the client, to other professionals, and to the institution (Gross, 1967).

Members of an occupation will identify and share the values and behaviours of their fellow specialists thereby forming a separate occupational community or sub-culture. In addition, members may eventually organize into associations such as unions or professional associations. By becoming structured groups, forces are established outside individual members that influence their characteristics and behaviour (Denton, 1978).

The concepts "profession" and "professional" conjure up an image, held by the community and by society, of prestige, authority, and responsibility. Illich (1975), amongst others, describes the dominance, the autocracy, and the authority of the professions. Medicine is usually considered the prototype of the professions for no other career or occupation in our society has gained as much expert authority, prestige, autonomy, and power as that of the doctor (Freidson, 1970). In Australian culture the relation between prestige, status and privilege is very apparent. It subsumes the notions of personal autonomy and influence due to commanding the resource of knowledge.

Obviously, all occupations have some degree of authority, responsibility and influence; the higher the prestige of the occupation, the greater the authority and the influence. Accordingly, occupations are rewarded by widely different incomes and working conditions reflecting their particular dominant place in their sphere of work and society in general.

PROFESSIONALIZATION AND MEDICINE

It is difficult to define exactly what is meant by the term "profession", as it is virtually impossible to get any authoritative agreement on it. Occupations that are called professions share certain distinguishing features which set them apart from other occupations. Freidson (1970) regards a profession to be a special kind of occupation and that its most strategic distinction lies in legitimate, organized autonomy; that is, the right to control its own work. "Ultimate power is freedom to do it my way" (Daniel, 1983:22). To be recognized as a professional by the public and as a colleague by the profession means that the clinician has demonstrated mastery over the knowledge and skills required of a professional activity.

Major characteristics

Various approaches have been made to define what a profession is and there is fairly good agreement about the defining characteristics of a profession. Those taking a historical view, such as Wilensky (1964), have been primarily concerned with defining the stages that occupations go through in becoming professions. Others, like Goode (1957), take the ahistorical approach by defining various attributes of professions that distinguish them from other occupations. The two views are actually closely related and from them, we can obtain an overview of the major characteristics or "core" features common to professions (Freidson, 1970): body of knowledge, service to the public, licence, and collegial organization.

Each profession, therefore, forms its own normative sub-culture covering a wide range of matters from language to relations with clients, colleagues, and the community. Overall, their sub-culture establishes its own body of shared and transmitted ideas, values, norms and standards towards which members of the profession are expected to orientate their

behaviour (Merton et al, 1957). The need for self-actualization and autonomy is very high.

Autonomy and control

The special nature of a profession is that it has been granted the right to determine what constitutes its work, who can do it, and how it should be carried out. Hall (1968) considers autonomy as the key element of professionalization on the basis of technical expertise, colleague control of behaviour, and community sanction. That is, the clinician's professional prestige rests upon technical qualifications and certification by society as a healer. Moreover, the professional's attitude is such that he or she is free to exercise his or her judgement and discretion. Doctors not only basically control the conditions of their own work, but to some extent, also the work of most of the other members of the health profession as well. This often causes a great deal of friction and conflict. Clearly, professional autonomy relating to the medical profession is not absolute. Although the profession has control over technical judgement, control over terms of practice is embodied in a series of laws, as for example, the hospital by-laws as I indicated earlier.

According to Freidson (1970) clinicians have power and authority because they create the social possibilities for acting sick because they are society's authority to define what is or is not illness. They decide who is sick and what should be done to deal with it. In essence clinicians serve as "gatekeepers" to professional health resources such as hospital facilities or prescription drugs as well as deciding on sickness benefit or insurance eligibility. These resources and social categories cannot be used without the permission of the doctor. It is these needs that provide the foundation for the authority of medicine and the professional control on the organization and delivery of services (Patrick & Scambler, 1986).

MEDICAL EDUCATION AND SOCIALIZATION

To understand the perspectives of doctors as a professional group with its own normative sub-culture with certain ideas, values and orientations, we must also consider the manner in which they are selected, trained, and socialized as medical professionals. That is, one way to study a profession is to discover the career-lines or "rite of passage" of people who follow it (van Gennep, 1965). For our purpose this requires identification of the significant phases of careers, and the institutional sequences in which they occur - as from premedical phase, to medical student to intern, registrar, practising clinician, etc. Hughes (1958) regards a career as a sort of running adjustment between the individual and the various facts of life and of his professional world. The adjustment is not always smooth, often creating anxiety, friction, and conflict.

Career decision and motivation

It seems that traditionally, there has been a great deal of occupational inheritance in the medical profession. Most Australian medical students come from private schools and from upper-middle class professional families (especially doctor's families), proprietary, or managerial family backgrounds. Various studies, such as those by Becker et al (1961), have reported rather idealistic reasons for entering a medical career such as the ability to help patients and intrinsic medical interest. These factors are in conformity with the social image of the medical profession, namely technical competence and altruism.

When asked the reason for choosing medicine as a profession one male student (third year) replied:

> "I chose medicine because I got high marks at HSC so why not use them. Also, mum's brother is a doctor and he had a bit of influence. But these are not the only

reasons. I like to help people; that sounds corny but it's true. Also money played a major role I must admit. It's nice to be comfortably off. Besides, you get a lot of respect too. Some see themselves as swish and cool but I hope that I see myself as rather human. My colleagues have had it pretty easy coming from private schools and professional parents. They perceive themselves as an elite and downgrade other faculties and professions."

Medical School

Various sociological studies have focused on the socialization process of the medical student for a professional role touching on the acquisition of knowledge and skills and the development of and changes in attitudes and values which are characteristic of the profession (Merton et al, 1957; Becker et al, 1972).

The effects of medical school are not clear-cut or easy to discern but what is demonstrated is that apart from gaining basic medical knowledge and techniques, certain norms and values are passed on. Fox (1957) found that medical students develop a tolerance for uncertainty and a detailed concern for patients, while Becker et al (1961) points out that the students developed an appreciation of clinical experience and medical responsibility for patients. Moreover, they learned to view disease and death as medical problems rather than as emotional issues. That is, there is a tendency to promote impersonal attitudes toward patients.

As the first student interviewed commented:
"The whole scientific rationale in medical school is to accept anything without thought to its moral implica tion. Apart from having to set certain standards they seem to teach us to be cold and clinical. Perhaps it's a way of toughening us up so that we can cope once we

get into that situation. The fact that there is no complete cure for most things has also been stressed quite a lot. We don't learn anything about other areas of interest let alone how a hospital or ward functions. Psychology is badly taught and only in a clinical way; not at all patient-oriented."

On the importance of psychology, a physician at the BBH remarked:

"Learning about human relations skills in medical school is a lot of bullshit. How? It's just trendy. Those few that take it see it as a soft option because there is no exam. You pick it up on the way anyhow."

However irrespective of such comments it is becoming obvious that there is a need for more education in the social sciences which would perhaps help the process of moulding a more humanitarian doctor, both highly skilled as well as sensitive and responsive to patient needs and anxieties.

Postgraduate training

Having completed three years of clinical training, the medical student is now eligible to graduate. However, the licence to practice is only granted after completing the seventh year of internship and residency. This period, according to many, is the proving ground where the doctor takes upon himself or herself the burden of responsibility and the way this is handled will determine his or her success or failure. It is during this seventh year that the internalization of the attributes of the doctor's role becomes most important; the time when many postgraduates come very close to developing an image of themselves as doctors.

In a way the postgraduate phase is an extension of medical school as the young doctor continues to absorb new knowledge and technical skills. It is also important to learn new organizational and interpersonal skills as training is now taking place in a different institutional context. This new environment brings with it new responsibilities, new interpersonal relations, and a series of negotiations with other hospital members on which the intern is dependent. The result is often a great deal of strain, stress, and conflict, as the newcomer tries to adjust to the anxiety-prone environment.

PROFESSIONALIZATION AND BUREAUCRACY

Differing orientations

Various studies have focused on the conflicts of professionals in bureaucratic organizations and their relations with management. Scott suggests that there are two primary reasons for conflict to emerge:

> "First, professionals participate in two systems - the profession and the organization - and their dual membership places important restrictions on the organization's attempt to deploy them in a rational manner with respect to its own goals. Second, the profession and the bureaucracy rest on fundamentally different principles of organization, and these divergent principles generate conflict between professionals and their employers in certain specific areas" (Scott, 1966:266).

The primary difference between professionalism and bureaucracy relates to the control structure, differing concepts of authority, and professional (cosmopolitan) and organizational (local) orientations. Professionalism, as I indicated is geared to self-restraint, adherence to professional norms, autonomy, and colleague control whereas the bureaucracy uses administrative or hierarchical authority and control. In a bureaucracy only those at the top of the tree make vital decisions whereas the professional is expected to make his or her own decisions consistent with the norms of the profession (Engel, 1969). The authority and power of doctors are based on technical expertise; the administrator's authority and power rest on their hierarchical position, on their leadership style and financial expertise (I include the Medical Superintendent under administration.) Both forms of control are extant in a hospital. A hospital is therefore faced with the requirement to find an appropriate balance between them.

According to Lansbury (1978), however, recent research has questioned the reality of conflict between the various professional groups and the bureaucracy. It is argued that not only do professions vary in their degree of compatibility with bureaucracies, but that individuals within the same profession differ in their adherence to certain values. Not all professionals are cosmopolitan but rather show various degrees of local-cosmopolitan orientation. However, it appears that the higher the prestige of the professional group and the more central their skills to the achievement of the organization's primary task, the more control the group assumes over professional matters and over the conditions under which they work (Goss, 1961).

In many organizations there is a reciprocal process of adaptation and accommodation accomplished through changes or modifications on both sides (Kornhauser, 1962). The main reasons for reaching some degree of mutual accommodation lies in the interdependency of both systems. Although this marriage is often somewhat shaky, it is necessary. The professional needs the facilities and resources of the complex organization in order to operate; the organization, in turn, cannot function without the specialized skills and knowledge of the specialist.

Apart from salaried medical staff, very few consultants at the BBH think and address issues organizationally and so a certain degree of conflict persists between the administration and the visiting medical staff. The barriers are mainly due to the hectic work schedules of the medical staff; the difficulty in gaining a broad participation in joint efforts by the medical staff because of their diversity; and the fact that they have to divide their interest between the interests of their private practices and the requirements of the hospital. The paradox in the relation of the visiting medical staff and the administration of the BBH is that both proclaim patient care as the primary task and yet their different perspectives often lead to conflict about this very responsibility.

Another problem is the fact that the clinician must operate within the various regulations of the hospital relating to specific activities such a surgical procedure, drug use, filling in of forms, etc. It is the task of the Medical Superintendent at the BBH to ensure that these rules are adhered to. Yet this does not always coincide with the individual clinician's freedom of choice and charge nurses are often very frustrated because the latter refuse to abide to certain administrative procedures.

The visiting medical staff at the BBH consider the hospital as their workshop designed to serve "their" patients. They are not organizationally oriented yet are indispensable to the effectiveness and efficiency of the hospital in terms of cost, quality, satisfaction, and service to the community (Schulz & Johnson, 1971).

In addition, under the impact of changes in the requirements of medical care the role of the clinician is changing. Modern medicine has become increasingly more technically complex and hospital-centred (Bloom, 1965). The clinician is therefore becoming more and more dependent upon other professional helpers to accomplish his or her task. New norms and standards of medical treatment have resulted because of new innovations, wide-ranging advances in knowledge, and improvements in medical equipment. This is the age of "team medicine" whereby the doctor has to rely upon other clinicians, nurses, paramedical personnel, technicians, and the hospital administration (Bloom, 1965). The professionalization of these groups has been stepped up considerably by technological advancement in the hospital. The doctor faces the dilema of sharing rewards and responsibilities which mark team effort but this is not in line with the authority and prestige he has gained. Consequently group effort may not be wholly congenial to him or her (Burling et al, 1956).

GENDER, POWER AND CONTROL

"Gender is fundamental to the way work is organized; and work is central in the social construction of gender." This is the view of Game and Pringle (1983:14) whose aim is to develop an understanding of the relations between gender, the labour process, and technological change, using also the hospital arena as an example. Mumford (1983) also comments on the importance of the status of "male" and "female" as a variable in health behaviour in that it illustrates important interrelationships, economics, family systems, culture, and the status structure of society.

Gender refers to the social meaning of being "male" or "female", focusing on the fundamental questions of identity and sexuality. What is of more importance and interest, however, is to look at gender relations within the BBH in order to understand the questions of authority, prestige, professionalism, power, and conflict. Above all, gender relations provide an insight into the historical relations between "men's" jobs and "women's" jobs in relation to the division of work in the hospital, and how change in the status quo is bringing with it strain, anxiety, hostility, and conflict.

Gender is not just about difference: it is about power and the domination of men over women who are supposed to play the subordinate role. Sexuality and power are integral to work relations and any change in the organization of work often provokes anxiety. Men fear their loss of power or try to prevent women from gaining power to which they are not entitled (Game and Pringle, 1983). Men's work should be seen to be masculine and to be experienced or empowering. Men have the skill to work with complex and sophisticated machines (technology and masculinity are very closely connected). Men feel degraded, reduced in status, and their sense of self is affronted if they do "women's" work. On the other hand, if women move into male areas of work they are classed as asexual "career women" or "sleeping their way

to the top" (Game and Pringle, 1983).

As far as the centrality of gender to control of the labour process is concerned, we need to distinguish between the various types of power and control within the organization. Whether we talk of formal power, referent power, or expert power, we tend to find a patriarchial form of control. This is clearly reflected, for example, in the primary division of labour in the BBH as well as the various occupational relations that occur within it. The primary division of labour indicates a sexual division of male medicine and female nursing (even though a greater number of males are entering the field). Paramedical staff, domestic personnel and other ancillary occupations are also predominantly filled by women.

Badgley (1975) has indicated that the division of labour by gender has often reinforced the subordinate vocational status of nursing tasks by social definitions of what constitutes appropriate women's work. Ideologically, nursing professionalism occupies an intermediate position in the hospital hierarchy of health professions. Within the BBH the existing social relations can be seen as reflecting the "natural" position of males and females in the home (Leeson and Gray, 1978). Although there are changes on the way there is still that degree of symbolism of the family (doctor/father, nurse/mother, patient/child) in the definition of jobs and authority relations (Game and Pringle, 1983).

CHAPTER 6
HEALTH PROFESSIONS IN CONFLICT

The various health professions within a complex organization like a hospital can be perceived

> "as loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name" (Bucher & Strauss, 1961:326).

Up to now we have viewed a profession largely as a relatively homogeneous community in which members share identity, values, interests, and orientations. Contrary to functional arguments, the conflict perspective suggests that not only are professions struggling to win and maintain the title of profession within society but are also in constant internal conflict.

THE MEDICAL PROFESSION

Georgopolous & Mann (1962) point out that according to research most conflict exists among the medical profession itself rather than between the medical specialists and other professional groups. The advantages of medical specialization carry certain hazards, namely the lack of time to treat the whole patient and the barriers to communication and understanding within the profession (Burling et al, 1956). The medical profession is not a group of people sharing the same title and values. There is a great divergency of enterprise and endeavour and there are cleavages that exist within the structure. There are different identities, different values, and different interests. Each group and emerging sub-group claim an area of expertise, thereby excluding others from it. It is theirs alone

based on arguments relating to unique mission, knowledge and skill, work process, client and colleagueship.

Doctors have the profession behind them and so they have to play both the organizational member role as well as the professional member role. It is as members of the profession that they may get locked into a kind of conflict that is quite contrary to what they as organizational members want to happen. This, of course, depends on how committed they are to the Hospital which will be developed further, shortly. It is a question of trying to make them understand that at times it is necessary for them to take off their professional hat and put on the organizational one. After all, they have an organizational committment to make the Hospital run efficiently.

If the doctors were to behave organizationally they would be taking a more bureaucratic role, but that is not the kind of role that they are been trained to take as doctors, as I discussed before. It is not the patient-oriented doctor role but a more socially related one.

OTHER HEALTH PROFESSIONS

Not all professions involved with the function of the BBH have equal power and prestige. Apart from the differences within the medical fraternity there are variations between the latter and other professional groups such as nursing, paramedical staff and administration. Power and status of the various professions in the Hospital can be judged on the basis of ultimate control and responsibility of the primary task, namely patient care. The visiting medical staff are the "leading" professions because they are closest to the technical core which in turn requires the highest degree of knowledge and skill; they have the ultimate control.

Most of the other paramedical professions in hospitals are organized around the works of the clinician. These ancillary occupations, which apart from nursing, include pharmacy, physiotherapy, social work, dietetics, etc., also have a certain responsibility and autonomy, but gain access to the patient only through the initiation and the instructions of the clinician. Indeed, they were in fact established on the assumption that they were there to assist the leading profession.

Freidson (1970) suggests that the nursing and paramedical occupations reflect four characteristic features that account for their subordinate position: (1) the technical knowledge employed by these groups tends to be discovered, developed, and approved by clinicians; (2) nurses and paramedical personnel usually assist the doctor in his work rather than replace the basic skills of diagnosis and treatment; (3) the work of nurses and paramedics largely occurs at the "request" of the doctor; and (4) the public ascribes considerably less prestige to non-doctor workers than to doctors.

A related point concerning prestige is the fact that at all levels in the BBH, the "leading" professions receive a far greater remuneration than those of the rest. In addition, it seems that the socio-economic backgrounds of those people recruited into the "lesser" professions are generally lower than those of doctors, coming from the middle, lower-middle and working-class. Although the profile is slowly changing, clinicians are predominantly male whereas women are found in much greater numbers in nursing and paramedical work.

NURSING - THE TROUBLED PROFESSION

Pressures and problems

Historically, the nursing service comprised essentially the entire hospital and even today it represents the largest health professional group. It is a most (if not the most) critical component in fulfilling the hospital's objective for patient care. At the same time, however, nursing is also called a "troubled occupation" having to face many of the problems that are confronting the health care industry overall.

Some argue that the marginality of the nursing profession is due to the relative absence of a number of those common characteristics of professional groups we mentioned previously (Etzioni, 1969). Although the degree of autonomy varies, somewhat, as to where the nurse is situated in the hierarchy, many still hold a subordinate position in the work setting with a relative absence of functional autonomy. The drive towards increasing professionalization is bringing nurses into conflict with hospital administrators and the medical profession (Anderson, 1973) and is reflected quite clearly in the field research dealing with the various types of patients and the operating theatre suite.

Contradictions of professionalism

With the development of a more complex division of labour, new patterns of authority, education requirements, the introduction of new technology and the reorganization of the work process, the role of the nurse at the BBH is changing. That is, there is a major shift towards professionalism and managerialism, causing internal tensions and anxiety within the nursing group which in turn is influencing its ability to relate effectively with the other occupational groups.

Clinical skill. For a start, the nursing profession is becoming more clincially skilled and therefore better educated and trained having moved into Colleges of Advanced Education and Universities. In Bendigo, as in many cities and country centres, new Faculties of Health Science have been established with enrolments increasing from year to year. It has given the nursing profession greater parity with medical and paramedical staff and lifted their status and prestige (Pittman, 1985). But although it may provide greater power for the highly qualified elite, it has left a second larger tier of less qualified nursing staff who are there to carry out the more basic nursing tasks. It has more or less split the nursing profession in two.

Total nursing care. Another illustration of the move towards bureaucratification in nursing, is the re-emphasis by nursing administrators and educators of the importance and necessity of "total nursing care". At the BBH, for example, this has resulted in a new form of work organization called "patient assignment" and involves the reunification of nursing tasks into a team effort. Each nurse is assigned a number of patients for whom she performs all tasks. This new approach to work represents a potential challenge to medical authority threatening the customary balance between doctor and nurse.

Nursing and management. In addition to the introduction of team nursing, another significant change in the work role of nursing has been the evolution of the Registered Nurses into an administrative role. Many nurses have pointed out to me that this development is a response to blocked mobility. Unlike medicine, nursing in Australia has never had a career structure that encourages and rewards expertise in clinical practice (Pittman, 1985). The career path is via the administrative ladder which means giving up the professional skills one has learnt and practiced at ward level.

The paradox in this development, however, is that while it allows the nurse greater professional status and less subordination to doctors, it reduces or eliminates the contact with patients; the very role she or he has professionally trained for. It means, as some agree that if the nurse becomes less able to function in the manner decreed by the profession, then in this sense, she or he has become deprofessionalized. Indeed, the same issue can be raised regarding the role of the Medical Superintendent in hospitals which is a case in point at the BBH.

Again the result has been a further division in this profession, notably the nursing division and the clinical nurses on the ward; it has created another "them and us" situation. In fact, many clinical nurses in hospitals complain that the administration has no idea as to what goes on in the ward and are simply pushing pens in their ivory tower.

The charge nurse. Changes in the organization of nursing work has also had its effect on the co-ordination of activities at ward level. The role of the charge nurse has become more complex and demanding and is the first step on the career ladder. Because of the pressure on them to develop formal managerial skills, many have already enrolled in administration courses at Colleges of Advanced Education and elsewhere. At the moment there are twenty four Registered Nurses enrolled in the Associate Diploma in Administration (Health) at the Bendigo College of Advanced Education, many of them from the BBH.

There is no doubt that some tension exists between the professionalism associated with clinical nursing and that which is called administration. Leeson and Gray (1978) argue that a rigid extended nursing hierarchy is conducive neither to professional attitudes nor to good morale. The charge nurse may now be less accountable to the doctor, but is more accountable to senior nurse managers who seem to have very little contact with

the clinical side of things anyway. Although the desire to be recognized as true professionals is growing, the current is running very much the other way, namely the relinquishing of the caring role, and the increasing bureaucratization due to the new structure.

On this whole issue of the drive by nurses towards increasing professionalization and the role conflicts which result, a senior surgeon at the Hospital angrily remarked:

> "It seems to me that a situation has developed where nurses have such a low estimation of their own worth that they now seek recognition by masquerading as quasi doctors. Their attempt at self-justification is rather pathetic because it is so unnecessary. They want to demonstrate their new found professionalism and independent status and that they are no longer to be regarded as our servants. I know several Senior Charge Nurses that are openly rebellious, disillusioned and disparing of the trend which divorces them from what they regard as proper nursing and turning them into fillers of forms and so called unit managers. Don't make me laugh."

Nursing organizations in Australia are belatedly trying to develop a clinical career ladder for nurses in the various hospitals. However, without recognition of clinical expertise, claims to autonomy and responsibility will fall on deaf ears. The introduction of a clinical career path may result in a skilled, tertiary educated nurse who is no longer the Cinderella of the health care system, and who works as an equal member of the health care team alongside the doctor.

TREND TOWARD UNIONIZATION

We can see that the health system does not fit well into the industrial mould. Badgley (1975) is of the opinion that in few other institutions of society is social and economic inequality among workers so entrenched and yet so generally unacknowledged as in the health industry. Stressing the alienation of some of the people from their work and the status inconsistencies and relative economic deprivation of many of them, he shows that the trend toward unionization, conflict, and strikes has been inevitable. Ehrenreich and Ehrenreich (1975) also agree that there is a real and conscious need for hospital employees to have meaningful work and to be adequately recognized for it, both materially and in terms of respect and status.

Reluctance to unionize

While there are obvious reasons why some nurses, for example, may want to join a union, there are some equally compelling reasons why the process for some has been slow and others have refused to join outright. In the first place, the major factor that has mitigated against unionization is because of ethical and professional norms reflected in the dedication to the creation of a therapeutic environment for the sick. The central product of hospital work is not some artefact of questionable value, but a service whose importance and value is self-evident (Schulz and Johnson, 1983). The desire to be of service to mankind still remains and cannot be satisfied by bringing home a pay check. (Indeed many hospital administrators and the Health Commission have often successfully exploited the employees' service ethic to avert unionization and strikes.)

Another reason for the reluctance to join a hospital union is that unions are generally associated with blue-collar employees. People who think of themselves as professionals have not always accepted such an association because blue-collar workers were

seen to have different needs, interests and demands. Finally, women, who make up a high percentage of employees in the health professions, as we indicated previously, have in the past been more difficult to organize than men. This may be due to the fact that they are often supplementary breadwinners in addition to having short term employment expectations. While purporting to be a self-governing profession, nursing has exercised only partial work autonomy, has received relatively low wages, and has to bear personally disruptive work schedules.

Changing attitudes

With the increased emphasis on managerial efficiency and effectiveness the BBH, like many other institutions of its kind, is becoming more "industrialized". More and more nurses, for example, are in the transitional period between perceiving their task as a calling and perceiving it as a job. Moreover, there has been a slow build-up of job frustration which has also been fueled by an awareness of women's roles and rights, by the impact of inflation, and by disenchantment with traditional values.

Nursing is in the throes of far reaching change, rejecting paternalism and the service ethic and of becoming a potentially subversive force. In addition, nurses have also made giant leaps towards becoming true professionals in the last few years. That is, professional nurses are beginning to identify with their profession rather than with the hospital that employs them (something doctors have always done to a large extent). They are seeking professional autonomy, self-control and a more assertive share in interactions with medical and administrative colleagues (Green, 1983).

THE NURSES STRIKE OF 1986

The year 1986 witnessed industrial conflict of unprecedented levels throwing the health care industry into chaos, when thousands of nurses throughout Victoria alone went out on indefinite strike in support of demands for a career structure within their wages award. The strike not only demonstrated a militancy that shocked many hospital administrators, politicians, and parts of the community, but it finally buried the image of the nursing profession as being docile and conservative. On the 31st October, nursing staff members of the Royal Australian Nursing Federation (RANF) withdrew their services from the BBH for a period of fifty days. Picket lines were set up and bans on all but emergency admissions were in force. Not only did the Hospital see a reduced level of activity for the year, having treated 10,334 patients against an estimated number of 11,340, but the effect of the strike left a great deal of bitterness and resentment all round, which is still being felt today.

As soon as the nurses walked out of their wards and into the streets, volunteers with nursing experience were sought by the Chief Executive Officer to keep the Hospital running, especially emergency service, including intensive care and the labour wards. This allowed most of the wards to be manned by registered nurses at a minimal level. However, this skeleton trained staff was not sufficient to enable the Hospital to admit elective patients. In addition, patients with minor illnesses were discharged and sections of the maternity, medical, and surgical wards had to be closed during the weekend. Patients in closed wards were distributed to those that remained open and experienced nursing staff were rostered to those patients that were very ill, leaving volunteers with little experience to those patients requiring a lower level of nursing. Those registered nurses who continued to work in the wards were under enormous strain and anxiety as well as having to bear some degree of harrassment by RANF members.

On the 9th December, the BBH approached a new crisis after nurses decided to walk out of the casualty and labor wards and were greeted by loud enthusiastic applause from the small band at the picket lines. Only one trained nurse remained on duty in Casualty while private maternity patients were advised to transfer to Mt. Alvernia, the local private Catholic hospital. There were now no midwives on duty when there would normally be four during the day and three in the evening.

Causes of the conflict

Behind all the emotion and frustration were two single causes to the dispute, namely the low wages and staff shortages. The irony of it all was borne of a genuine attempt by the RANF, the Victorian State Government, and the hospitals to redress those problems. However, the award and the career structure handed down by the Victorian Industrial Relations Commission (VIRC) in July was not accepted by the RANF. The latter felt that under this new award, nurses in fact received no, or minor salary increases, while others were being downgraded from positions they have held for years (The Weekend Australian Newspaper, 15/11/1986:21).

The RANF identified twenty outstanding claims of the new award around which it could not reach agreement with the Government. Rather than going through the established industrial relations process, the RANF tried to pressure the Government for a direct and quick political solution. Nurses threatened not to return to work until a wage package agreement was "signed and sealed" with the Government.

The two problems of low wages and insufficient staff have been confronting the health industry for more than half a decade and have only been addressed in little more than piecemeal fashion by successive State Governments and health administrators. Nurses confronted by low wages, long hours, and poor career

prospects are abandoning the health industry in large numbers, with Australia having to import nurses from the United Kingdom, Europe, and North America to staff increasingly heavy burdened hospitals. Because of staff shortages, the job of nursing is no longer rewarding and satisfying for some.

This loss of manpower in the health system is not only due to low wages and morale but to a former lack of government funding, a rationalization of hospitals in the early 1980s, and the high mobility among nurses into private agencies and overseas. In addition, taking trainee nurses out of hospitals and into Colleges of Advanced Education will, most likely, make staff shortages even worse. This is already being felt quite strongly at the BBH.

The Minister and the Militant

During the strike, a great deal of hostility and distrust was shown on each side. The RANF made plain its dislike of the Victorian Minister of Health branding him as "the undertaker" with his uncompromising stand and brinkmanship games. It has doubts about a Government that has failed to recognize the extreme sensitivity of nurses to matters affecting their salaries and status. The Government, on the other hand, is suspicious of the State Secretary and a union it brands as "the Nurses Liberation Front", which repudiates an agreement it made only a few months earlier, has links with extreme left elements in the labour movement, and is overbearingly militant.

The Minister and the State Secretary are the key public actors and representatives of the parties in conflict. They are considered in some ways as far apart philosophically as Labour and Liberal. Although both are members of the Victorian Australian Labour Party (ALP), she is an "Old Guard" member of the socialist left faction; he is aligned to the right of the party.

Each individual, naturally, perceives the dispute from their own vantage point - she representing a profession docile but now fed up with poor pay; a hospital system in a mess and on the verge of collapse; and a patronizing behaviour of doctors, the Government, and the media. He believes the Government has been sympathetic and generous in its efforts to redress the longstanding inequities in the nursing profession. Not only that but he is adamant that the only place that this dispute can be resolved formally is by the arbitration process, nowhere else.

Reactions to the conflict by hospital staff

The overwhelming support for the union leadership and the strike was reflected in various comments made by the nursing staff at the BBH. The RANF job representative held that:

> "Nurses are angry and frustrated by continued failure by the Government to act on injustices. What is happening in Victoria is that nurses who have been in the profession for many years waiting for wages and conditions to get better are still waiting. On top of that the new classification has failed to even alter the problems with the career structure, let alone resolve them. The fact that a charge nurse can go to Melbourne or locally to Mt Alvernia and in both cases get paid more money for doing the same job indicates that there is something not quite right. I don't think there has ever been an issue which has produced such strong feeling and brought nurses so much closer together."

The following sentiments were expressed quite strongly by a nurse teacher:

> "From the standpoint of history the nurses strike is remarkable enough to be described as revolutionary. I believe that nursing has been made the barefoot Cinderella of the professions for a hundred years and that it is long, long past time that nurses should

stand up at last, make some very proper demands, and refuse to be fobbed off once again by patronising ministers and well-cushioned public servants. Nurses have been the victims of exploitation and disregard by successive governments. It is quite disreputable that this supposedly progressive State Government has aligned itself so immovably against the nurses, and so forced the conflict to such bitter lengths and desperate measures."

Very much in line with the previous comments was the emotional outburst by a student nurse who said:

"Never before has Bendigo seen such an industrial and political stand as that taken by the nurses. We left our jobs, our patients, and postings in the hospitals, to show this town exactly how desperate andhow angry we all feel. I've watched nurses walk out with tears in their eyes but it's a matter of showing just how united we are to fight for the future of our patients care, our career structure and our wages. Do nothing and we face a dismal future. do something and we are put in a position of hursing innocent people. After seven years nursing it was a soul-searching time for me and a very big decision for all of us."

It seemed that for many nursing staff the decision to walk out of the Hospital was a typical example of role conflict as discussed in Chapter 3. It became a question of patients versus colleagues; a tale of torn loyalties. The nurse interacts directly with a variety of professionals and non-professionals, including the public. The role she or he plays in the Hospital is conditioned by the expectations of that role set.

The Charge Nurse from the Children's Ward spelled out her dominant feelings:

> "I was going to strike but when I realized there was no cover for my little patients, I didn't, even though I fully support the RANF strike action. Illness can be an extremely traumatic experience for children; they are so vulnerable that I couldn't possibly leave them. May peers didn't agree because they somehow didn't understand my special responsibilities at the time. I felt very vulnerable myself."

According to the Charge Nurse at the maternity wing:

> "Not only am I in charge of the third floor but I'm an RANF representative as well. Naturally, I'm always torn between two loyalties. I walked out because I thought of the future of nursing but by doing so I couldn't think of my patients. It was too stressful; I had to cut myself completely off. Mind you, I couldn't really have gone without consciously knowing that someone else was looking after my patients."

The aftermath of the strike

The strike finally ended at an emotional mass meeting of more than 3,500 nurses at Melbourne's Sports and Entertainment Centre on December 19th. In the New Year, Victoria's nurses were awarded a new wage package with the Government finally agreeing that its previous wage allocation under the June award was insufficient. Despite all the public posturing by both sides during the conflict, the nurses did prove themselves strong enough industrially to achieve their goal.

Badgley (1975:5) points out that if the needs and rights of health workers as well as the health of patients and public can be preserved, then strikes can be an important catalyst for change in our society. Yet, he adds that

"unionization of health workers and the pressures toward more stringent cost controls in the health field clash head on, with jobs being reclassified, and redefined as a result, and with necessary preoccupation with cost efficiency, increasing conflicts may be anticipated in the years ahead".

However, many bitter feelings and an air of resentment remains towards those in the Hospital who didn't support the militant action that was taken by the RANF members. Some of the conflict within the nursing division today still stems from the dispute in 1986 when some of the clinical nurses, and especially some of the members from nursing administration remained on duty. As one nurse on the picket line at the time commented:

"Those so-called nurses who are helping inside are just scabs. We know who they are and they better look out. One day they'll be sorry because when all this is over and they want to change things or need us for something, we'll tell them where to get off."

As far as the executive staff were concerned, the striking nurses had the support of the Chief Executive Officer and the Director of Nursing. Most of the medical staff also seemed sympathetic to the cause. The Medical Superintendent, on the other hand, regarded the situation as a rather complex matter and strongly disagreed with the Director of Nursing on the issue. Although he was sympathetic for the introduction of a better career structure for nurses and felt it was not unreasonable to stage some protest, he was of the opinion that they should have come back earlier and let the industrial process settle the dispute. When the nurses finally walked out of the casualty and labour wards as well, the Medical Superintendent became most distressed that nurses who are part of the Bendigo community, should no longer care for their fellow man. His views were aired publicly on local television and informally throughout the Hospital.

This action upset many of the nurses reflected by the remarks of one of the charge nurses:

> "The Super and those VMOs on his side who did not support us can go and jump. They can look after their own Residents from now on. I won't cover up again for them when they don't really know what they're about or when they're not here on duty. From now on I'm going to take care of number one."

There is no doubt that the nurses have achieved a victory by flexing their muscle. One can notice the change in the BBH where some senior nurses have become more self-assured and will be more assertive in the future, perhaps continuing to take on the Government, the Hospital, and the medical profession. The general relations between professional nurses and the medical staff seems to be deteriorating with time. Many nursing administrators in hospitals and senior nursing educators in Nursing Schools and Colleges of Advanced Education have the attitude that nursing is for nurses and doctoring is for the medical staff. Each is seen as a profession in their own right and they don't necessarily have to meet.

CHAPTER 7
THE HOSPITAL PATIENT

THE CONCEPT OF ILLNESS AND THE ROUTE TO THE HOSPITAL

When individuals seek medical care they engage in the process of "becoming a patient". This process can be perceived as moving between two interrelated sets of demands, values, actions and social interactions. On the one hand, the everyday life of the patient, and on the other, the professional therapeutic system of organized medicine. (Robinson, 1978).

Folta and Deck (1966) are of the opinion that health and illness are relative concepts that are determined in part by culture and historical periods, and in part by the health professionals. Illness is thus not solely a biological and physical phenomenon but also a social phenomenon as it is constantly being redefined. New knowledge is used to define new forms of deviance which are then integrated into existing institutions. Medicine is a social institution with its own unique set of norms which prescribe and proscribe behaviour in illness. The diagnosis of illness and the treatment of illness are fitted with particular orientations and methods of practice, the use of which are delegated to the medical profession (Bloom 1965).

As far as the medical institution is concerned, the definition of illness is quite significant and has various consequences (Denton 1978). First, what is considered illness has consequences for individuals within society because it influences the social interaction patterns between the sick person or patient (we shall use them synonymously) and those around him or her. Second, the definition of illness has consequences for the power of the medical institution relative to

the other institutions within the society. In its role of arbiter of social values the medical institution has the power of social control with the doctor acting as its representative (Armstrong 1983).

Illness behaviour

Once illness is perceived, it is followed by certain patterns of behaviour that are, basically, socially determined. To understand illness behaviour has relevance for the medical profession whose task is to treat illness conditions and those people who provide and administer medical services. The question that should be asked is how do people come to occupy the social position of sick person or patient? The answer lies in two directions; one deals with varying exposure to illness conditions, while the other focuses upon different perceptions of those conditions as well as different response to them.

Not only are individuals differentially exposed to illness conditions but they also differ in their readiness to interpret a certain sign as a symptom of illness as well as differ in their readiness to seek help for or to consult for any illness condition which they perceive. Whether or not individuals are prepared to consult about the symptoms they perceive is likely to be influenced of how they view the implications for themselves or others of "being a patient" and performing the patient role.

Illness, then is a personal event to the extent that we evaluate for ourselves the meaning of any symptoms of which we become aware. Suchman (1965) has attempted to describe a person's illness experience by analyzing this behaviour in terms of social patterns accompanying the seeking, finding and carrying out of medical care. Not only is the illness experience separated into stages, but more importantly, they are described in terms of social, cultural as well as psychological factors. He distinguishes five stages of illness experience (1) the

symptom experience, (2) the assumption of the sick role, (3) medical care contact, (4) the dependent - patient role, and (5) recovery and rehabilitation. According to Suchman, when individuals perceive themselves becoming sick they can pass through as many as these five different response stages, depending upon their interpretation of their illness experience.

There are, of course, variations to these stages, where, for example, certain stages may be skipped as in the case of acute, unexpected heart failure. Also the duration of each stage varies depending on the person and the social factors involved. Each stage in the Suchman model requires the sick person to take different kinds of decisions and actions. Illness behaviour is very much a question of self-perception and how it relates to the individual's understanding of a particular symptom as well as the influence of the social network and its own sociolcultural orientation.

In addition, socio-demographic variables, such as age and sex, are also consistent predictors of seeking medical care. Elderly people and females generally report more illness than younger people and males. This view about women is also held by Roberts (1985) who finds that women tend to consider themselves more unhealthy than do men and go to the doctor more often than men; they take more medicines than men; and they seem to spend more time looking after other people's health than men do.

The sick role. We can now turn to the response of people following the perception of illness. Again, the concept of role is useful because it focuses attention on the point at which the individual and society ("others") come together whereby the person is then confronted with the demands and expectations of others. That is, like all social roles, the sick role is a pattern of expected behaviour with characteristic obligations and privileges. The sick role will be defined not only from the doctor's point of view, but by all the other occupations grouped

around the Hospital patient, such as nurses, paramedicals, and support staff.

I have already noted that the medical institution is engaged in social control which means that it controls aspects of ideas and knowledge which support the existing social system. The sick role may be seen in that context.

Parsons (1951) believed that the primary function of the sick role is to control the disruptive effect of illness in society by making sure that those individuals who do become ill are returned to a state of health as quickly as possible, thereby contributing to the social stability and health of society. Implicit in his concept of the sick role is the idea that medicine is an institution for the social control of deviant behaviour. Freidson (1970) in fact expressed concern that the institution of medicine is taking responsibility for an ever greater proportion of behaviours defined as deviant. Indeed, the medical profession has been highly successful in gaining authority to define deviant behaviours as illness - behaviour properly handled only by the medical practitions. The doctor is identified as the gatekeeper who controls access to the sick role, and thus determines the official labelling of conditions as sickness or health (Morgan et al, 1985).

Different views of the sick role concept. Although Parson's concept of the sick role is an influential concept and framework for explaining illness-related behaviour such as temporary acute physical illness, it has nevertheless provoked some criticism and debate. Criticism has centred on its empirical validity in relation to different types of conditions and different groups in the population. The exceptional conditions are minor illnesses, chronic illness, mental disorder and pregnancy. I agree, especially with cases of healthy pregnancy. There is also a variation in the extents to which the expectations of the sick role are accepted by different groups relating to age, sex, social

class and ethnic minorities in society such as children, the aged and people living in poverty.

Despite the considerable criticism of Parson's sick role concept, I regard it as important that he has given us an "ideal type" which nevertheless is useful in serving as a base for comparing and differentiating. Once the patient becomes hospitalized, the sick role is then defined not only from the doctor's point of view, but also by a host of others, such as nurses, paramedical staff and lay personnel. It is a useful and viable framework of analyzing the different types of patients coming into the Hospital pointing to certain similarities as well as pointing to cases where the model does not apply.

The classical care model

Because health institutions differ in the broad goals of patient care and assumptious about disease, this gives rise to differences in staff attitudes and role expectations, their relations with patients and the organization of activities on the ward. From these characteristics, Coe (1970) has developed three "ideal type" models of institutional organization which characterize different hospital-based patient care: the custodial care model, the classical (acute) care model, and the rehabilitation care model. Although one must keep in mind that, in reality, overlaps between the various types of care occur, nonetheless, the models provide an analytical lever by which we can study the relations between patients and hospital personnel. The basic characteristics of these models are presented in Table 2.

The classical care model now forms the most prevalent pattern of hospital care and illustrates the situation at the BBH. Patients are being treated primarily for acute conditions. The goal is the cure and care of the patients and once diagnosis and treatment have taken place, they are discharged from the

hospital. They can then take up their normal social roles without the benefit of further help, unless there is a special problem needing non-medical support such as the help of social workers.

Table 2. Models of patient care

Dimension	Custodial	Classical	Rehabilitation
1. (Stated goal)	Comfort	Care	Restoration
2. Assumptions about disease process	Incurable	Reversible	Mutable
- Therapy	Sporadic	Central	Supplementary
- Sick Role	Permanent	Temporary	Intermittent
3. Patient Motivation	Obedience to institutional rules	Obedience to "doctor's orders"	Achieve mastery
4. Resulting Institutional Model	Total institution	Acute general hospital	Rehabilitation centre

After Coe (1970)

Even though most activities relating to medical care are usually routine, the imperative emergencies that arise require quick decisive action. In addition, interaction between staff and patients tends to be episodic and oriented towards the implementation of specific procedures which are often carried out by different hospital personnel. Patients are thus generally expected to be passive and to cooperate with the hospital staff in order to expedite the curative process. In fact, the classical model assumes unquestioning obedience to medical authority.

Most of the time hospital patients are, by virtue of their sickness, quite dependent and sometimes unable actively to make decisions for themselves. They are people to whom as well as for whom things must be done so that the illness can be reversible. Consequently, the patient is expected to be the passive recipient of medical care, who is cooperative and agreeable. Often, patients are regarded as objects of medical procedures. That is, both socially and biologically, the patient becomes "a case" which is mainly to be dealt with in a category rather than an interactional framework. This often creates a gulf between staff and patients with the latter finding little opportunity to experience shared meanings and sentiments during the therapeutic process.

THE PATIENT ROLE

The patient's position

Irrespective of the general social status of the patient, once he or she becomes hospitalized, he or she is placed in a new social situation, namely a rather lower status. The experience of being hospitalized adds yet another dimension to the experience of being sick. Once being admitted, the patient assumes an organizational position with all the implications for normative compliance and sanctions.

As the intruder, (usually a temporary one at that), the patient is in the least powerful position of all the people in the ward. It is a position characterized by low status authority; something quite different to which the patient had been accustomed in the outside world. The patient is now subject to the particular social demands characteristic of the ward. In addition, his or her relations with hospital staff are also the source of potentially strong influences on the way he or she responds to the patient role. Congalton and Najman, (1971) point out, that one of the problems confronting the hospital patient is the difficulty of adjusting to the situation where the person's status is different from that to which he or she has been accustomed.

Patients may find that they have to respond to two sources of power and authority based on dependency (Denton, 1978). First, the hospital has an interest in maintaining control over the patient's activities thereby minimizing any disruption of institutional routine. Taking up the patient role in this case involves the surrender of choice over many things that the patient is quite capable of doing. This is entirely for the convenience of running the ward and not for the caring of the patient. That is, the patient must adjust to social demands, not so much related to his "getting better" but to the maintenance of the social system (Coser, 1962). This is achieved by the

hospital personnel placing demands on patients that restrict their activities. The latter may leave, but because the institution has something that they need to improve their health, they relinquish the authority they had in their positions outside.

Second, the patient is under the control of the doctor who becomes the authority figure and usually dictates the patient's activities on the basis of greater knowledge and skill. Generally, patients have very little voice in the matters of the hospital, nor have they seemed to desire one, because they assume that professionals know what's best for them (especially those from lower socio-economic backgrounds).

The idea of the sick role played as an outsider has taken on a new meaning and is no longer the privileged one which may have been appropriate at home. As Straus so aptly defines the role of being a patient:

> "A primary requirement of the patient is that he accept a dependency status, submit to the ministration of others, relinquish control of his environment, and assume an identity based primarily on the classification of his primary organic problem." (Straus 1972:209)

Variations in the patient situation

The patient role in the hospital should not be viewed as if it were everywhere the same. It varies for two main reasons, namely the type of setting in the institution and the sociodemographic and illness characteristics of the patient. Regarding the first reason, there are differences in the patient role at the BBH, depending on whether, for example, the patient is in a surgical ward, the maternity wing or the operating theatre.

Characteristics of patients that affect how they will react to sickness and hospitalization as well as how the Hospital personnel will treat them, will also result in variations in the patient role. Social class, for example, plays a significant part in affecting the patient role and consists of several component parts. First, the higher the level of education the better able one is to understand the culture of the patient setting and how to communicate with medical and nursing personnel. Second, one's income usually determines whether the patient opts for private medical cover which may result in receiving more personal attention from staff and greater explanation of treatment. Cultural values, attitudes, norms, and beliefs are also important determinants of how the patient will react to hospitialization.

The patient's new life style

Admission to a hospital is for many people a traumatic, stressful, and conflicting experience. Congalton and Najman (1971) regard hospitalization, in sociological terms, as an example of culture clash. Into this esoteric way of life and into this highly developed hospital culture, steps the patient from the culture of the world outside bringing with him or her the physical and mental habits of a lifetime. This can be visualized as moving between two interrelated sets of demands, actions, values and social interactions. On the one hand the everyday life of the patient, and on the other, the professional therapeutic system of the Hospital.

The hospital must accommodate between contrasting organizational demands (resting upon a limited resource base) and the orientations which individual participants bring to the institution. While the hospital is trying to maintain adequate primacy of instrumental functions, namely treating patients, the latter are seeking mainly emotional support and psychic gratifications (Rosengren and Lefton, 1969). The conflict

arises because in its pursuit to apply the medical technology for treating the patients, the hospital must somehow induct the patient into these roles, values, and attitudes which will permit it to address itself to this primary task.

Loss of self-identity

The admission procedure is the first of a series of initiation rites into the patient's new life style. The socialization process results in what medical sociologists regard as depersonalization or the loss of self-identity. Coe (1978) states that patients are alienated from their usual life-style and reduced to a largely impersonal status through three basic mechanisms of hospital processing: (1)stripping, (2)control of resources, and (3)restriction of mobility. Hospitals vary as to the degree to which these aspects of control are applied depending on size and the type of hospital that it is.

Certain routines are established which include designated times for eating, bed and shower, and interaction with visitors. In the patient's life style, there are also changes in privacy such as exposing the body during examination as well as the manipulation of personal body functions. This loss of identity is exacerbated by the alien physical environment in which the patient finds himself and the deprivation of many of the significant symbols associated with the home (furnishing, knick-knacks etc).

Control of resources centres mainly on the control of information about the patient's medical condition. One of the major complaints of patients is the difficulty they have in obtaining information about themselves from their doctors and even some nursing personnel. The restriction of mobility indicates that the patient's movements are usually controlled by the Charge Nurse in the ward. Moreover, when patients do leave the ward to travel to another area of the hospital, they are generally accompanied by a nurse or porter.

The purpose here is not to debate whether the role deprivation, the unfamiliar routines, changes in privacy, and removal of familiar significant symbols are right or wrong. Rather, the concern centres around the fact that when all these small changes are added together they culminate in patients experiencing an alien land; that is a life style completely different from that of non-patients.

Adjustment to hospitalization

In most cases, when individuals enter an alien culture or a situation in which their social position and the expectations attached to it are uncertain, they will endeavour to adjust in order to regain a feeling of security and certainty. That is, the patient will seek some sense of identity and location in the new environment and will thus search for new rules to cope with the situation.

It is under those circumstances that the patient will try and seek out one of the doctors or nurses so that they can explain things to them in language that they can understand and show interest in their worries and anxieties by giving them a chance to talk about themselves. Unfortunately, very often there is evidence of a serious failure of communication between some patients (and relatives) and hospital staff. Patients are often uncertain, lack the knowledge and vocabulary, forget or don't accept or misunderstand what they are told. The medical or nursing staff, on the other hand, may have different perceptions about the patient's needs or simply lack the required communication skills necessary for an effective dialogue.

Since there is no preparatory socialization into the patient role, patients have no set standard for behaviour which means that their actions and responses are neither standardized nor certain. Patients either accept or reject their role, with various gradations between the two extremes. When accepting the

patient role, the individual usually feels that the doctor knows best or the nursing staff is trying to care for him. Lorber (1975) and Cartwright (1964) suggest that the older and more poorly educated patients tend to be more submissive to hospital rules, whereas the younger or better educated are less likely to express highly conforming attitudes.

Reactions of medical personnel

Medical personnel sanction patients on the grounds of whether they define them as having been "good" or "bad" patients. The value labels are attached depending on the specific actions of the patient. For example, in one particular study, of patient-care units, staff members referred to "bad" as those patients "asking too many questions; refusing to do what they were told to do; insisting on 'carrying on' from the hospital bed as if they were either at home or in their offices; and making, what the staff considered, excessive demands." (Taylor, 1970:147). In another study, patients who were considered "good" were perceived by the medical staff as cooperative and uncomplaining (Lorber 1975). One can deduct from these studies that generally medical personnel define good patients as those who demand the amount of attention that they think they should rightfully claim based on their particular illness, and vice versa. Thus, whether a patient is considered good or bad in the eyes of the medical personnel will depend on such variables as the patient's condition, time used, routines broken, or attention required.

THE DOCTOR AND PATIENT RELATION

The focus of our interest is the BBH and gaining some understanding of the therapeutic dialogue in this particular setting will highlight the world of different types of patients and the multiple conflicts that occur between the various patients on the wards. The social system of the therapeutic relations will be examined from two sociological perspectives, namely functional and conflict.

The functional perspective

The doctor-patient relation as depicted by Parsons is one characterized by harmony, even though there is a "competency gap" between the expert medical practitioner and the lay patient. The competency gap produces a basic asymmetry in the therapeutic relation where the doctor, as professional and social control agent plays the dominant role, by virture of his or her specialized knowledge and skill and the high status accorded to the medical profession. By defining what the problem is and deciding what should be done, the social deviant relearns and plays a normal role again. The Parsons model seems to be quite applicable in cases which involve acute disease episodes instead of chronic diseases. Many of the acute ill patients are dependent on the medical staff for immediate or intensive care.

A more elaborate conceptualization of the doctor-patient relation, which has many of the attributes Parsons claims it has, are developed by Szasz and Hollender (1978). Their approach also adopts a functional perspective as well as portraying the relationship in terms of harmony and consensus. These authors have identified three basic types of doctor-patient relationship, namely: activity-passivity, guidance-co-operation, and mutual participation. The type of relationship which occurs is viewed as determined by the patient's illness as well as the doctor's definition and regulation of the event.

In practice, the nature of the therapeutic encounter is often subject to negotiation between the two parties. Not only that but there are also situations where the patient guides and the doctor cooperates. That is, at certain times the patient is more knowledgable or capable to take care of himself or herself. There is a task boundary around that patient because it's the patient who manages his or her own affairs.

In interviewing patients, Taylor (1970) found that patients would like two roles, namely a submissive role and a cooperative role. Those who want an omniscient doctor and play a submissive patient role fall into several categories - those who are critically ill; those at lower socio-economic levels who have been culturally conditioned that way; and those who value a dependent role.

On the other hand, those patients who would prefer a cooperative role are quite willing to allow the doctor to make the diagnosis and to accommodate themselves to the necessary demands of the hospital and its specialists. However, they also want to become active participants and cooperate in order to respond more rapidly to the treatment offered. They are usually people from the middle or higher class and those with minor illnesses or mothers undergoing a normal birth.

The conflict perspectives

The literature discussed here is a reflection of what I discovered quite clearly in my own research. Although these discoveries were made independently of the literature they reinforce what Freidson and Tucket have to say.

Based on his empirical research findings, Freidson (1970,1975) challenges the Parsonian model by pointing to its lack of reality, ignoring the patient's point of view, and overlooking conflict in human relations. Freidson draws

attention to the potential conflict in the doctor-patient relation in terms of a "clash" of perspectives between lay and professional conceptions about the organization of illness. The medical professional's views are moulded by professional education, clinical experience and training, and membership in the medical profession, forming a set of values and norms for behaviour in the doctor's role. The lay patient's views are influenced by the need to cope with a particular problem, the important social influence of the family, as well as his or her cultural and social understanding of the situation and the range of possible responses to it. In reality, the viewpoints of the layman and the professional are never really wholly synonomous. Consequently, there is usually a measure of latent conflict in many patient-doctor relations.

Conflict in the doctor's role. Built into the social role of being a doctor, Tuckett (1976) indicates that there are various conflicts that are innate to it and that are part of the script that the actor has to work with. One important source of conflict lies in the differing priorities and interests of doctor and patient. Whereas the individual patient is concerned only with his or her particular illness, the doctor has to balance the needs of other patients thereby keeeping the ward situation functioning efficiently. This means balancing the allocaton of the scarce resources of time, skill, and materials between the individual patients. Another set of related problems involves the doctor's concern for the patient's welfare as against the concern for the patient's relatives.

One of the more significant conflicts in the BBH is the relation of the medical staff who are in training (Resident Medical Officers) and their patients. Most RMO's want to become specialists and are just passing through the ward on the way to achieving their career ambition. They may find themselves in a conflict between their own career interests and those of their

patient. The emphasis in medicine becomes a rather narrow study of disease with only minimal attention being paid to the broader context of the person. This, of course, in turn, influences the negative perception that the patient will have of his or her doctor.

A final set of conflicts in the doctor role are those that arise in any occupational role, namely, the multiple roles that the focal person may have, such as father, husband, football coach, and so on. This inter-role conflict is particularly important in medicine because illness and death cannot wait.

Social class conflict. Cultures clash when professionals and their clients come from different socio-economic backgrounds; the medical subculture of the upper middle and upper class medical practitioner versus the culture of the poor lower class patients. (Maykovich 1980.) This medical subculture is quite noticable in hospitals where we find the public facilities such as the Outpatients Clinics, Casualty and the public wards as compared to the private facilities comprising the VMO's consulting rooms and the private wards. Middle-class people more often than those of the working-class enter hospitals as private patients. They seem to be more privileged being able to get more privacy, avoiding delay, and have a closer relation with the doctor.

The alienation of indigent patients from the Hospital is aggravated by professional prejudice, which is sometimes reflected in the type of treatment provided; psychological inhibitions induced by poverty and struggle; perception of illness; and the barrier to effective communication due to the lack of articulation.

Other sources of conflict. In addition to the various conflicts outlined above, there are other, more situational or personal sources of conflict. Because the doctor sees a patient on a continuous basis, the latter's symptoms are one among many, whereas to the patient, the illness is the most significant thing. For the doctor, the therapeutic situation is a normal state of affairs instead of a traumatic, threatening experience.

One can appreciate Freidson's approach to doctor-patient relations as a functional clash of perspectives. Sometimes these conflicts have been resolved through negotiations and bargaining. This suggests that the encounter is open, with each party having the scope to influence the outcome to some extent. In most cases, however, this type of encounter is limited because of the powerful position of the doctor and the patient's lack of skill to negotiate. Doctors are more powerful during the encounter because they control access to information not only where diagnosis, prognosis and treatments certain, but also to conceal medical uncertainty. (Morgan et al. 1985).

Communication in doctor-patient relations

Very often when these two parties bring their particular perspectives into the therapeutic relation various problems emerge due to a break down in communication. Very often there is lack of communication between the doctor and the patient about each other's expectations and a failure on both sides to explain the assumptions and rationales underlying their own behaviour. (Hingson et al. 1981.) It seems that middle-class patients are able to communicate with the doctor and other hospital staff more easily than working-class patients but higher expectations usually make them more critical.

Some of the reasons for poor medical communication seem to be a lack of interest in the patient and the problem; lack of consideration and sensitivity; the short time that the doctor spends with the patient; that the patient is not interested or does not want to be told; or the use of esoteric language and medical jargon. Others again tend to describe the issue in terms of information control and of the perpetuation of uncertainty (Morgan et al. 1985). It is suggested that this is a device, used by doctors, as a means of maintaining professional antonomy and power by creating social distance between doctor and patient as well as creating patient dependence. Doctors, nurses and patients need to interpret their respective roles in the same way if there is to be effective communication between them.

PART III

THE BENDIGO AND NORTHERN DISTRICT BASE HOSPITAL

This part of the thesis is the beginning of the field work report on the BBH. It starts with an overview of the Hospital, touching on its historical development, objectives and constraints.

This is followed by an analysis of the managing system which involves the Board and the Executive, namely the Chief Executive Officer, the Deputy Chief Executive Officer, the Medical Superintendent and the Director of Nursing.

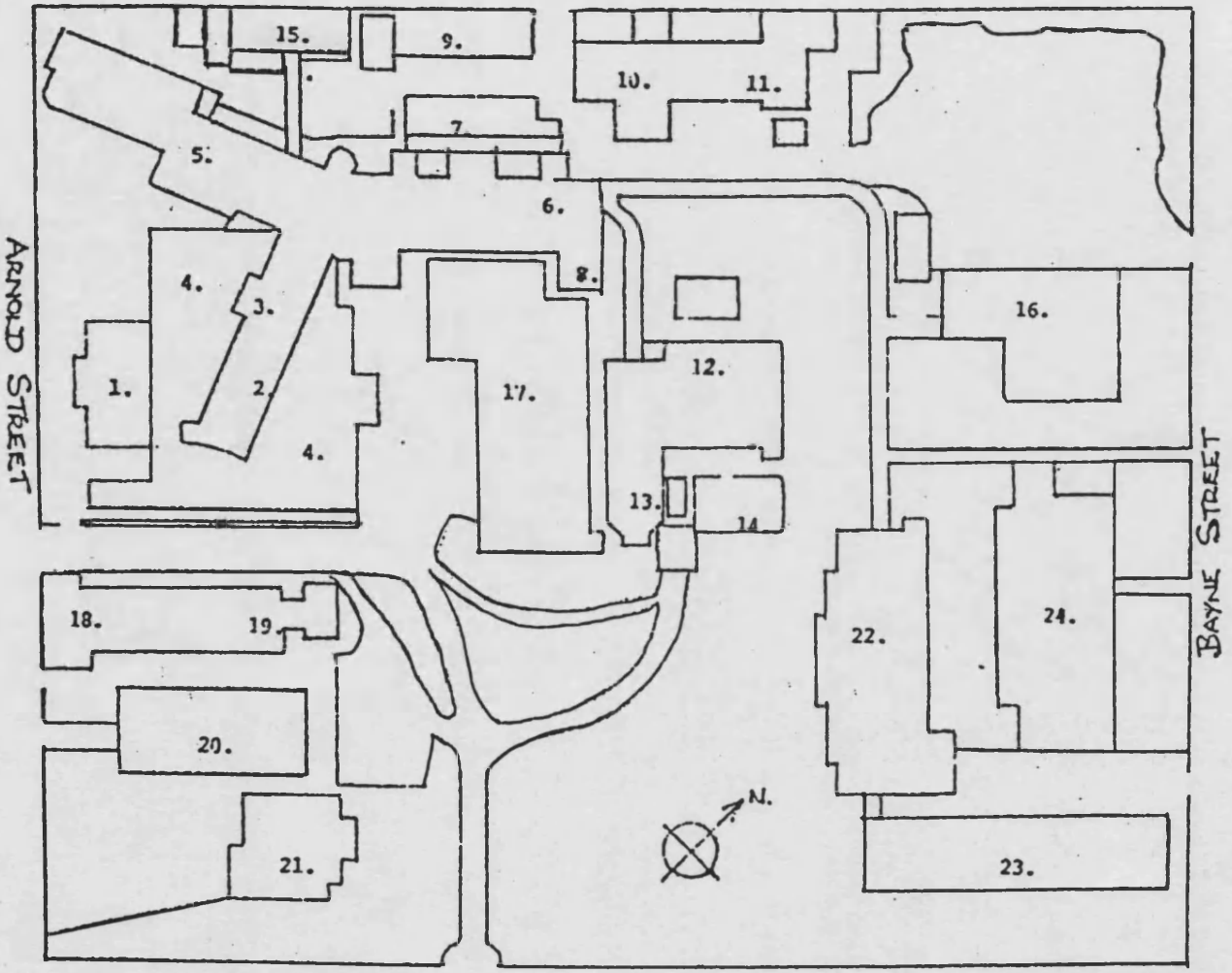
Finally, there is a discussion of the major services of the Hospital, comprising the Medical, Nursing, Paramedical and General Administration Divisions.

CHAPTER 8
OVERVIEW OF THE BBH

The BBH is one of the more technically complex public general hospitals in the State of Victoria. Its primary task or mission is to provide health care service for the Bendigo District (population of approximately 66,000) and to act as a major regional referral centre for the Loddon Campaspe-Mallee Region (the Health Department's Region 3 with an additional population of 81,000). More than two thirds of patients treated come from the Bendigo District. The hierarchical structure of the public general hospitals in this region comprise the following: two Base hospitals, namely Bendigo and Mildura being the major referral centres for the region; two other General Hospitals acting as sub-regional referral centres; and a number of small community hospitals at a level of complexity appropriate to their size. The BBH offers administrative services to smaller associated hospitals in the region and acts as a "feeder" hospital to the large Metropolitan Teaching Hospitals, especially the Austin Hospital in Melbourne. The BBH also has a close working relation with the Bendigo Home and Hospital for the Aged and co-operates with the two Community Health Centres and the private Catholic Hospital, Mt Alvernia.

Figure 4 depicts the site of the BBH.

Figure 4. The site of the BBH.



Legend to Figure 4.

1. Dental Clinic, R.M.O.'s Rest Room, Eye Clinic
   Blood Bank
2. Floor 1 - Ward 6
   Floor 2 - Stanistreet House (incl. Special
   (including Special Baby Care Unit)
   Floor 3 - Stanistreet House
   Floor 4 - Stanistreet House (Delivery Suite)
3. Floor 1 - Intensive Care Unit
4. Radiology
   Pharmacy
   Outpatients Clinic
   Medical Records
   Casualty - Admissions
   Social Workers
5. Floor 1 - Kurmala Lower
   District Nursing
   Floor 2 - Kurmala Unit 1
   Day Ward
   Floor 3 - Kurmala Unit 3
6. Catering Officer
7. Kitchen
8. Staff Social Club room
9. Maintenance workshops
10. Linen room
11. Bulk store
12. Ground floor - Ward 7 (Childrens' Ward)
    Floor 1 - Staff Cafeteria
    Floor 2 - Conference Centre
13. Ground floor - Physiotherapy
    Speech Pathology
    Floor 1 - C.S.S.D.
    Floor 2 - Ward 8 (Infectious Ward)
14. Occupational Therapy
15. Staff amenities block (modesty)
16. Tutorial block - Lecture rooms
    Nurses' Library
17. Hyett Block
    Ground floor - Administration
    Medical
    Nursing
    General Office
    Switchboard
    Hospital Chaplain
    Domestic Services Superviser
    First floor - Operating theatres
    Second floor - Wards
    Third floor - Wards
18. Nursing staff amenities
19. Library
    Post-graduate medical education
20. Commonwealth Health Laboratory
21. Staff residence
22. Main Nurses' Home
23. Pethard Wing -Nurses' Home
24. Chalet

Historical perspective

The BBH was established in 1853 to service the need of some 33,000 people, mainly diggers, who had come to seek their fortunes in the search for gold. It was called the Bendigo Gold Fields General Hospital. It seems that nothing could stop the growth and expansion of the Hospital which was open to all members of the community, depending entirely on public and government financial support. By the early 1880s Bendigo was becoming a prosperous provincial centre. During the late 1880s the Hospital had to treat many patients suffering from infectious diseases such as diptheria, dysentery, cholera, and typhoid. Private subscriptions to hospital fund enabled the institutions to maintain a good standard of patient care.

By 1900 the Hospital expanded from a small slab and weatherboard building serving a new frontier mining town, to a substantial institution serving a prosperous mining and commercial centre. The current geographic layout of the Hospital is a legacy from the development of that time. The ten years between 1920 and 1930 saw many changes to the Hospital, one of which was having its status raised in 1927 to the Bendigo Base Hospital and in 1930 it became known as the Bendigo and Northern District Base Hospital. The Hospital's base area was extended and so was its service. The Hospital was no longer primarily for the poor but provided a full range of medical services for all financial classes of the community, comprising a private, semi-private, and public ward. In 1935, the Kurmala wing was opened providing accommodation for both maternity and general cases. In 1969 a new casualty department opened and in 1978 the Hyett Block and the new Operating Theatre Suite were completed. Gradually the Hospital continued to upgrade its facilities, and combined with the population growth of the region, it is now one of the most up-to-date and efficiently-equipped Base Hospitals in the State of Victoria.

Socio/economic/demographic characteristics of the Bendigo Region

The increasing pressure on the BBH for hospital services, especially the use of public facilities, is to a large extent a reflection of the various characteristics of the region. In summary the Bendigo Region has the following characteristics:

- low population density reflecting the rural and provincial nature of the region. Bendigo is largely reliant on service and primary industries with a few heavy secondary industry establishments.

- an aged population with approximately 12% of that population in the 65+ years age group. This group is the major user of health care particularly in the specialties of orthopaedics, cancer services, and ophthalmology.

- a population of "white", Anglo-Saxon background with very few migrants or Aboriginals.

- a low labour participation rate reflected in a fairly high unemployment rate and a significant level of "dependants" or people not in the labour force.

- an "income poor" district with a high proportion of low income facilities.

(Source: Bureau of Statistics, 1985)

Services

The Hospital is a fairly complex, labour-intensive organization. It has 258 available beds and employs about 1,050 people (including full-time and part-time). During 1986/87 10,434 people were treated and 4,953 operations performed.

Today the Hospital provides hospital based health care facilities and a range of specialist medical and surgical services appropriate to meet the needs of the region. Together with the expansion, the area has attracted many specialist medical staff although more are needed. The Hospital currently provides the following inpatient services: obstetrics; gynaecology; paediatrics; general surgery and medicine; ear, nose and throat; orthopaedics; urology; opthalmology; dental care; special medicine; and intensive and coronary care. Also about 1,000 patients are able to be admitted and treated under the care of general practitioners who are members of the Affiliated Medical Staff. In addition, the Hospital provides various outpatient services such as accident/emergency; medical clinics supporting the above mentioned specialists; district nursing and dentistry.

The BBH Profile is shown in Table 3 indicating the services offered and the available resources.

Table 3: Profile of the BBH

1. SERVICES

(a)	Acute Hospital Services	Last Full Year 1986/87	
	Available beds	258	
	Admissions (Inpatients)	10,434	
	Average length of stay	6,0	
	Patient days	62,749	
	% Occupancy	67	
	Radiology Examinations	23,878	
	Outpatient Attendances	131,198	
	Operations	4,953	
	Births	884	
	Physiotherapy Treatments	27,284	
(b)	Inpatient Services	Number Treated	
	Medical	2,079	
	Surgical	4,594	
	Obstetrics/Gynaecology	1,987	
	General Practice	1,112	
	Paediatrics	662	
	Total	10,434	

2. RESOURCES

Recurrent Operating Budget ($'000)		
* Gross expenditure	24,558.0	
* Revenue	4,944.1	
* State Government grant	19,613.9	(79.4%)
Minor Works		
* State Government grant	118.9	
Capital Works and Equipment		
* State Government grant	417.4	
Numbers of Employees (equivalent full time)		
* Nursing	438	
* Medical (staff only)	28	
* Paramedical and Ancillary	40	
* Indirect staff	280	
* Total number of employees	786	
(1,050 employees, incl. full & part-time)		

Objectives

Objectives connote greater degrees of specificity and serve to translate a ststemnts of mission into specific concrete terms against which results can be measured. Goals indicate where an enterprise is going; tasks are what it has to do to get there. The Hospital's ability to be of use to its primary beneficiary, the patient, rests in its continuation to perform its primary task effectively.

The Annual Report (1986/87) of the BBH provides a mission statement which attempts to catch the essence of the Hospital and which reads as follows:

> "To provide Health Care services as the Regional Referral Hospital in Region 3 in accordance with the Hospital Role and Function Statement, and facilitate improvement in Health Care in the community within the limit of available resources."

Within the overall mission there are multiple operational or strategic goals and the tasks for achieving them. They both vary in relative importance but operate simultaneously. Again, the Annual Report (1986/87) of the Hospital lists the following objectives:

"- to make available health care to those who require it based on medical need and in accordance with the Hospital Role and Function Statement as agreed with the Regional Director of Health.

- to make available relief, including maintenance and treatment or cure of, or attention to any disease or ailment, or any injury consequent on any accident, medical and/or surgical attendance, medicine, nursing assistance, support or aid of any kind or in any form to such persons as are entitled thereto, under the Hospitals and Charities Act.

- to provide facilities for the carrying out of investigations into diseases, injuries or other matters affecting the human body.

- to provide facilities for the training of nurses, doctors, paramedical staff and support staff, as required from time to time."

Thus the BBH is a complex multiple-task institution which, to perform its many functions has to relate to a complex environment. The tasks are therefore to provide care for the sick and injured; to advance research in scientific medicine; and to provide education to hospital personnel. Obviously, patient care is the major task of the Hospital reflecting the sociocultural values and norms of its community. According to Georgopolous and Mann (1962), this emphasis on patient care and treatment permeates the value system and multiple tasks of the hospital, even though there are constraints of economics, technology, and organizational abilities. The BBH is a public hospital in that most of the patients are public. However, the institution also caters for private patients which are usually housed in the Kurmala Wing. The private patient is one who on admission to the Hospital elects for treatment by private medical practitioners in a private capacity.

As far as the multiple tasks of patient care, teaching and research are concerned there does not seem to be a major problem at the BBH. Research is minimal and the training of nurses has been phased out from the School of Nursing and transferred over to the Bendigo College of Advanced Education although nurses also receive practical training at the Hospital. There are occasions when this causes some conflict between the medical and the nursing staff due to pressure of time and importance. The training of interns and residents does not seem to cause any particular problems in relation to clashes between different objectives.

In complex organizations like this Hospital it also often occurs that different occupational divisions or sub-systems such as the doctors, nurses and administrative staff tend to give different priorities to their own objectives; that is each group perceives the tasks from its own position due to its training, values, expectations and requirements and prestige. These groups are composed of individuals who also have particular interests and aims which they want to satisfy or achieve. Consequently all these levels of tasks can lead to disruption, conflict and interference with the achievement of the Hospital's official goal, namely patient care. This can result at times in a certain degree of intergroup conflict.

There are also differences in the perception of tasks from the point of view of the administrative and the medical staff. Administrators are very money conscious and expect the Hospital to be managed efficiently and economically as well as being financially solvent. The visiting medical staff, on the other hand, are the prime users of resources in the place and yet show very little interest in becoming involved in the issue of resource allocation and financial priorities. Their main concern is that their patients receive the appropriate treatment regardless of cost.

As the Chief Executive Officer indicated:

> "The objectives of this hospital and my task in it is to serve the community in the best and fairest way possible. I have to justify my job and run this estab lishment as economically and effectively as possible making optimum use of resources and facilities. But that's not always easy because you need a great deal of power to do that. The biggest obstacle to achieving my objectives is money.

The medical staff do not quite see it that way. Some are perhaps beginning to appreciate the financial problems but many are still ignorant or are just not interested. They don't care about funding as long as they get their equipment and their patients through the system."

State funding

The BBH is directly dependent upon the environment for its inputs - patients, doctors and other personnel, supplies, facilities, and capital. Of particular importance is the role played by Government, especially that of the Victorian Health Department/Commission. The type and extent of financial support in subsidies or grants affects the operative goal of the BBH - quality and efficiency. Table 2 shows that in 1986/87, 79.4% of actual operating receipts came from Government grants.

The conflict of values lies in the need to look after the sick and injured and to try to do so within the financial constraints imposed by government funding. In the past patient care was always emphasized as a paramount value of our society but the dollar sign is increasingly assuming greater importance. Although the mission statement of the BBH indicates the aim of providing health care, this is qualified by the addtion of a rider to the effect that this care will be provided within the limits of available resources or finance. Herein lie the problems and the conflict for the Board and the Chief Executive Officer with a given quality of administrative and health care personnel together with a given amount of money, the quality of care will vary inversely with that quantity provided. The administration is constantly faced with striking some sort of balance between the two.

When asked about this problem the Chief Executive Officer replied:

> "It's a problem which is very difficult to pin down. In many ways its a mixed bag of various variables such as professionalism, too many patients, too few nurses and paramedics, not enough facilities and equipment, and the question of finance. Mind you, funds are not everything because what you also need is the right mental and managerial approach."

However, according to Levy (1975), some public hospital administrators complain that the system of State Government funding provides no incentive for exercising managerial skills. If a hospital is able to reduce its expenditure through more efficient working methods, then the government grants may also be reduced and the "surplus" allocated to a less-efficient institution rather than furthering the quantity and quality of patient care at the more efficient hospital. In the words of another administrator at the BBH:

> "We maintain that we're rolling along quite well but that's not really so because finances are holding us back. We just squirt the oil into the noisy bearings of the old machine instead of overhauling it altogether properly. Fiscal control seems to be everywhere."

The Hospital Agreements Programme is designated to give the BBH more autonomy by setting priority goals and indicators on the volume of service to be delivered in the following years. That is, the Hospital is accountable for its achievements and in return for this commitment the Government will endeavour to fund the Hospital to an agreed level. However, due to the nurses strike, shortage of staff, and ever increasing paperwork, the BBH was not able to reach some of the throughput targets during 1986/87.

Again, the Chief Executive Officer explained:

"My biggest frustration is the bureaucracy of the Health Commission which is enormous including the amount of requests and the paper work. Too many people ask too many questions and there is no trade off; it's all a one way trip. The Regional Office only adds to the bureaucracy. With the Health Agreement they keep a close check on you. We are more accountable now than ever before."

Picking up a newspaper or journal in Victoria these days we come across many headings, some of which read as follows:

"Hospitals in crisis"; "Our dollar-hungry hospitals"; "Unfulfilled promises"; "Your health is at risk"; or "The failure of medicine".

Everybody seems to be aware now of the frightening escalation of medical costs, the squeeze on health revenue and expenditure, and some of the draconian consequences. Being a member of the Hospital Board and the Finance Committee brings one face to face with the stark reality of the critical situation. The State health budget has now increased enormously to fund the ever increasing deficits of the hospitals. Most of the expenditure at the BBH goes on salaries and wages with the biggest proportion to the nursing division.

A further pressure on the Hospital is effect of the introduction of "Medicare" in 1984. This system is financed in part by a levy on taxable income and provides access without charge to public hospital beds and to in- and out-patient treatment by hospital doctors as well as other benefits. Private health insurance remains available for private hospital cover, for doctor-of-choice cover in public hospitals, and for a growing variety of ancillary services. "Medicare" has thrown an extra load on the Hospital as the number of people with private cover

has dropped dramatically with more and more relying on the public health system.

Presenting problems

The effect of cuts: In many hospitals around the State the stringent cuts in finance have resulted in sick people having to wait too long for surgical and other treatment as well as many beds being closed. One of the surgeons from the BBH angrily remarked:

> "This hospital is no longer being run to best serve the people of the district. People shouldn't get sick at weekends unless they give ample notice to the hospital. There are fewer beds overall now for patients than five years ago and the length of waiting lists for most types of surgery has increased and is below the State average. It is an absolute disgrace how the bureaucratic intrusions are slowing everything down here. We surgeons are being suppressed all along the line."

Another visiting medical officer commented:

> "This Hospital can be an angry place because of the problems with financial constraints, red tape and government control. Bureaucrats make money decisions without asking those at the grass roots what's going on. We act as the patient's adjunct and can put a different slant on things."

Staff shortages: There has always been a staffing shortage in some departments, making it difficult, if not impossible, for the Hospital to operate at full capacity. In the last year or so, the Nursing Division, in particular has experienced ongoing problems with a staffing shortage all round, especially in the Operating Theatre Suite. This has been partly due to resignations and also a general shortage of trained operating

theatre staff in the State of Victoria. Commenting on the problem of resource scarcity the Director of Nursing remarked:

> "This hospital is about ten years behind others I know as far as staffing and equipment is concerned. The financial situation is a big worry for me because I can't maintain the sort of levels of service necessary. My biggest problem is attracting qualified staff because of the two level system. That is our girls are paid less than their counterpart in the metropolitan area for the same responsibilities. This hospital is graded lower because its in the country. If we haven't got the money we have to cut back on staffing and the standard of patient care will drop. At the moment there are not enough Registered Nurses (RNs) to do the supervising, more complicated tasks and cover meal breaks. The greatest proportion of staff are the State Enrolled Nurses (SENs) who are often given the responsibility beyond their level of training. This is a big worry."

Other areas which have been experiencing staff shortages are in pharmacy, physiotherapy and occupational therapy, medical records, and various positions in administration such as personnel, stores, and secretarial staff. In the next few years the Hospital may also experience a shortage of high quality medical staff. It seems to be very difficult to entice medical and paramedical staff to the country region.

Finally, apart from budget cuts and staffing shortages, several other factors have contributed to the problems facing the BBH. They can be listed as recurrent industrial disputes, an aging community, soaring cost of high technological medicine, the 38 hour week for hospital staff, and bureaucratic bungling at all levels of government.

All these various reasons have aggravated a critical situation which is causing some heartache to a great number of people, not only in the community but to hospital personnel including administrators, doctors, and nurses.

Reaction and proaction

The problems at the BBH did not evolve overnight. It has taken years of political and budgetary neglect to bring the situation to such a state as it is today.

Apart from being affected by the rationalization of the public health system for the last few years, the BBH seems to have been rather conservatively run for many years under the previous Chief Executive Officer which has apparently also contributed to staff shortage and lack of facilities. According to one of the key administrators:

> "This hospital has been very conservatively managed in the past and when the funds were there during the 70s the CEO at the time felt that what we had was good enough. When the flood gates closed at the end of the decade it was too late. Now of course the Government is trimming the fat and we are now penalized for being so short sighted, while other hospitals can sit back and manage reasonably well. We are now going to catch up. Accountants are box people; what you needed was someone who could negotiate and play politics. All we are doing now is cow-towing to the Government; it's backstopping and not problem solving."

When asked about his own style of management the CEO reflected and replied:

> "I think I'm a bit more outgoing than my predecessor and perhaps not so controlled and conservative. People who went through the war and the depression think differently. I came through a time when everything was

outward and upward. My tertiary training has also taught me to think conceptually and not react to issues. Youth, I think also plays a role in how you perceive things. I punt more and become more adventurous. Our organization needs punters right now because we have a lot of catching up to do but in the present climate things are rather chaotic."

Individuals, groups and organizations generally, can function more smoothly and accomplish tasks more easily when resources are adequate. There is no doubt that cost containment has also contributed to staff shortages which has resulted in a lack of experienced staff and low staff morale. The fact that money is a scarce resource has created a situation that contains the prerequisites for stress and conflict.

CHAPTER 9
THE MANAGING SYSTEM

DIFFERENTIATION AND INFLUENCE

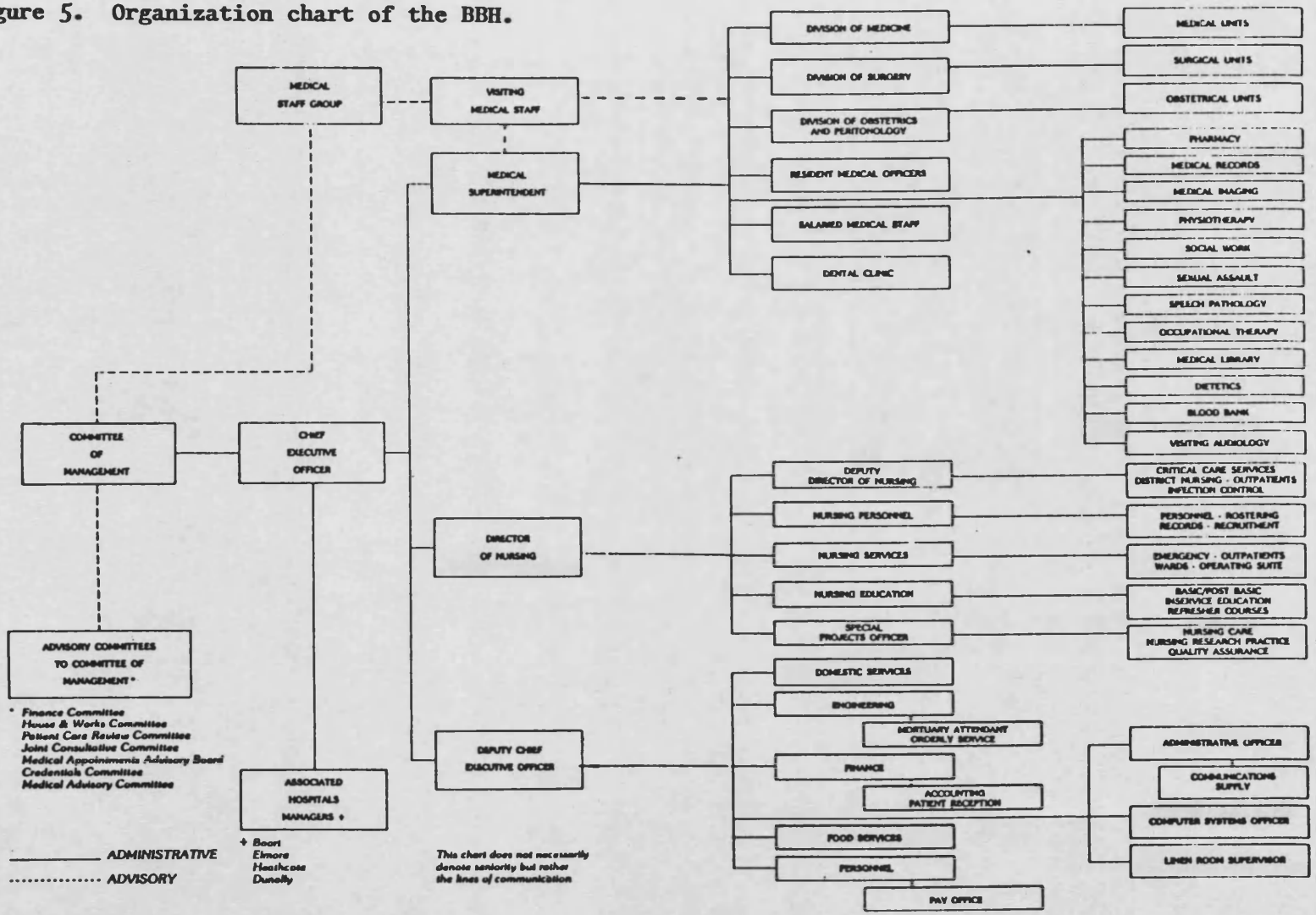
Work differentiation and the authority system

This section deals with differentiation within the socio-technical system of the BBH focusing on work differentiation with respect to the main task; the administrative hierarchy reflected in the organizational chart; the allocation and distribution of authority sanctioned by formal processes or by the recognition of professional skill and knowledge; and the status and career system referring to ranking within the Hospital according to education and training in line with the requirements arising from the main task of patient care.

In Australian public hospitals, specialization is achieved on a disciplinary (knowledge and skill) or functional basis, for example medical, nursing, paramedical, domestic, engineering, finance, catering department; and as an intradisciplinary basis with general surgery, orthopaedic surgery, ENT surgery and so on. The BBH, like most others of its type, is organized under the three broad divisions - medical services, nursing division, and general services. The role of professionalization as used here is conceived not so much as an attribute of individuals or occupation but as a structural characteristic of the Hospital. That is, it refers to the skill level of the operating core component and its personnel.

The BBH organization chart in Figure 5 portrays the administrative structure and the relations of the various services and departments engaged in patient care, reflecting some of the major features of specialization or differentiation.

Figure 5. Organization chart of the BBH.



In addition to the organization structure the BBH by-laws serve to regulate the conduct of the Hospital, especially the function of the various Committees and various rules and regulations relating to the medical staff. The by-laws are produced by the Board of Management and approved by the Health Commission.

As will soon become quite clear, the chart only bears a vague resemblance to the actual organization. It omits to show the varied and complex relations within the Hospital and the power and autonomy of the medical staff who assume a position of primary importance. The professional bureaucracy is a highly democratic structure, especially for the professional staff in the operating core. Not only do they control their own work, but they also seek collective control of the various administrative decisions that affect them (Mintzberg 1979). Although the chart portrays the position of the medical staff as outside the line of authority, the doctors exert power throughout the Hospital structure at all levels. The Board, the Chief Executive Officer, the medical staff, the Director of Nursing and the rest of the employees each wield varying amounts of influence or power.

Allocation and distribution of power

The elements that are different in the voluntary hospital organization stem primarily

> "from the power relationships, the control relationships and the alternative available to each group in what can here best be seen as a negotiated relationship and are constantly subject to renegotiation. They stem out of the alternative means of leverage and the amount of power behind that leverage that is available to each party involved in the negotiation." (Gordon, 1962:72)

Power and political processes pervade many of the individual and group relations that take place in the BBH. Many of the things that go on in the Hospital can be viewed as a struggle for power among individuals and groups who each fight for their own interests and sometimes form coalitions to achieve their ends.

According to Gordon (1962), the distinguishing characteristic of the Hospital is not dual authority as an issue in itself or distinctive in itself. Instead, it is the autonomy of the medical staff from control by unlicenced persons over whatever falls within the area of their professional task. In addition, it is the reliance of the Board and the Executive upon the machinery and behaviour of a self-governing medical staff organization.

The unique power and authority structure in the BBH significantly influences and complicates the role of the key players in top administration. It makes the problems of control and co-ordination rather complex.

The 'line of command' and the visitors

Each visiting medical officer is appointed by the Board under a quasi-contractual relation with the Hospital. Although the Board is the Hospital's ultimate source of authority it has only limited defacto authority over the medical staff who maintain control over medical matters, yet at the same time they are the most important actors (apart from the patient) who have a virtual monopoly on medical expertise and knowledge and without whom the BBH could not function. The Hospital cannot practice medicine; only the doctor is legally licenced to practice medicine on patients. Moreover, there is almost no administrative routine established there which cannot be abrogated or countermanded by the doctor claiming medical emergency.

Thus, on the one hand there is the collegial organization of the visiting medical staff (although it, too, is ranked on bureaucratic lines into professional hierarchies) and on the other hand there is the bureaucratic arrangement of offices which make up the administration and support services. What we have is a conflict between two systems of status at the BBH as postulated by Chester Barnard (1968) and developed further by Smith (1955) and Viguers (1983).

The usual pattern of authority emanates from the Board to the Executive with the Chief Executive Officer as the chief co-ordinator and the Deputy Chief Executive Officer, Medical Superintendent, and Director of Nursing responsible for their respective divisions. The individual visiting medical officer is in a unique position by enjoying the privilege of freedom of movement in two directions. He can view the institution as a service agency or external body against which he can have claims or he can view himself part of the BBH giving him the free mobility as a sole professional agent moving up and down the hierarchy with free access to the Executive and Chairman of the Board, as well as reaching these parties through the Medical Staff Group. It is only in certain administrative matters that the doctor is responsible to the Medical Superintendent and ultimately to the Board. Overall, the status of the doctor is one quite independent of the Hospital, the Board, and the Chief Executive Officer. The latter really has no authority over the doctor except to a certain degree in the control of finance.

The presence of two lines of authority can also be expressed in a dual system of values that pervades the BBH. That is, the Hospital is under conflicting imperatives of cost saving efficiency and professionalism. The Chief Executive Officer is forced to focus upon the contingencies of fiscal survival and balancing the budget which comes into conflict with the doctor's desire to uphold the institution's value of service judged on the basis of clinical efficiency (and not how much it costs). It must

be remembered that it is the medical staff who largely influence hospital costs through decisions on patient admissions, the ordering of diagnostic and therapeutic equipment and supplies, and the determination of length of stay.

The decision-making process for the day-to-day running of the Hospital is contained within a power relation between the administration, the medical staff, and, to some extent, nursing administration. In fact, at times it can be pinpointed down to a few of the most preeminent surgeons who hold the greatest power and thus often dominate the resource decisions in the Hospital.

Although there seems to be a general level of satisfaction on the part of the medical staff regarding their equipment and supplies, many feel exasperated is asked to justify requested items. This, however, is necessary because some of the surgeons who frequently utilize the Operating Theatre Suite are in fact spending above their allocated budget and continue to do so irrespective of the need for cost containment which is often spelled out clearly by the Chief Executive Officer. The visiting medical officers are sensitive about the question of cost containment and feel this to be a threat to their practice.

Because of the increasing technological nature of surgery, major capital requests are continuously under consideration at Board meetings. Those doctors representing the medical staff on the Board constantly remind it that without equipment and supplies the BBH could not generate the necessary through put of patients. The doctors are emphasize the substantial financial contribution they are making because of their major role in patient care.

On the one hand economic efficiency imposes the requirements of closer co-ordination and integration of the functional elements of the institution. On the other hand, professional values encourage both the separation of managerial responsibility and autonomy of the visiting medical staff. This situation makes

the Chief Executive Officer's task rather difficult and tenuous at times. The reality is that the Hospital depends for its livelihood on the medical staff. Strategically, they can relegate activities to the sacrosanct area of "practice" whenever they feel it is necessary and suits their own interest. So far they are not being held back or hampered to a great extent.

The occupational groups in the Hospital most affected by the dual system are the nursing staff who perform health care tasks on the various wards as well as pharmacy, radiology, admissions, etc. even though these are under the jurisdiction of the Medical Superintendent. Often at the BBH nursing employees receive directions from the Charge Nurse who in turn is responsible to the nursing administrative hierarchy subject to various rules and regulations. Yet at the same time these nurses are the recipient of the doctor's orders for his patients and are thus obliged to carry out those orders in a professionally competent manner. So the nurse is caught in a conflict between the expectations of the doctor that his orders by followed and the expectations of the administrator (Charge Nurse or Area Co-ordinator) that ward procedures will be complied with (Corwin, 1961). This is a typical example of cutting across managerial boundaries and will be explored more fully in the following sections.

THE BOARD

I was appointed to the Board of Management of the BBH in October 1986 and have often found myself pondering over the various precarious situations that face members of the Board, like myself. The Board of this social-purpose, non-profit and quasi-public institution, is responsible for dealing with complexities not like those of any other organization. There is talk of high-quality patient care and yet this object is not only limited to the resources available and influenced by the degree of cooperation between the specialized parties, but is also to a large extent non-operational. This results in vague sub-goal statements and no knowledge as to who has set them, how much agreement there is concerning them and how much commitment; targets that are occasionally set but rarely met; and standards of clinical care not defined let alone understood by the layman like myself.

In addition the authority and responsibility of key positions in the Hospital are fuzzy even though job descriptions are available. There is also no proper performance evaluation and even if this came to a rather negative result, very little can be done unless one went through a whole range of procedures and unpleasantries.

Another puzzle confronting me is the decision-making process and the communication patterns in the organization. I still don't know today, about who has the relative information on certain issue and how that information is shared. Coupled with the appropriateness of the decision-making process is the aspect of the communication flow and the effectiveness of the various committees that relate the numerous sub-systems to each other.

Given this state of affairs it is no wonder that many board members are often faced with the difficulty of making a decision under circumstances that are somewhat uncertain and

incomprehensible. Members like myself are called on to provide health services under changing conditions of medicine, of administration and of financial support. There is a change of emphasis in what is expected of board members in this Hospital and I hope that my colleagues and I are qualified enough to face this challenge and the new phase into which Hospitals generally are now entering. After all our role is partly, to protect the community's interest and its investment in the institution.

Membership

The Board (and the Executive) are at the strategic apex (Mintzberg, 1979) concerned with the overall mission of the BBH, allocating resources, directing the institution, and managing its relations with the external environment. The Board composed of twelve members meets once a month, at which time it receives routine reports from the Chief Executive Officer and the various permanent advisory sub-committees of the Board as well as correspondence from outside organizations related to the Hospital.

In addition to the twelve members, the Executive (Chief Executive Officer, Medical Superintendent, Director of Nursing and Deputy Chief Executive Officer) and the Chairman of the Medical Staff Group also attend but without voting rights. The sub-committees that meet on a regular basis are the Finance, House and Works, Patient Care Review and Joint Consultative (see Figure 6).

The twelve members of the Board are citizens from the local community who have attained a certain status in business or in the professions. They are appointed by the Victorian Health Department (through the exercise of political patronage some would claim) and offer their services without pay. The Chairman, a Dairy Industry Consultant, who was also a Senior Executive of a dairy for many years, has not only extensive industrial and administrative experience behind him, but has also been Chairman of the BBH on three previous occasions. There are also two

medical personnel on the Board, one a Paediatrician at the BBH and the other a Medical Practitioner from one of the Regional Community Health Centres. The rest of the Board members include people with backgrounds in law, nursing, industrial relations business, and tertiary education.

The Health Department seems to frown on too many medical staff being appointed because of their expert power, their high social status and charisma, and suspicion of furthering their self-interest (Grant, 1985). This has certainly occured on various occasions at the BBH, where several prominent surgeons have tried to be appointed to the Board on many occasions but were not granted a seat on unspecified grounds.

Members of the Board interest themselves mainly in the overall policies of the BBH, its financial stability, and, to some degree, the impression it makes on the community. The Board's role basically involves determining the Hospital's objectives and role relating to the control of Hospital funds, the provision of necessary equipment and facilities, appointing senior staff, and establishing policies for the attainment of those objectives as well as monitoring their achievement; all within the constraints set by the Health Commission. Most of the planning of the Hospital is placed with the Executive but still leaving the Board with the function of approval or rejection.

The Board has a boundary-spanning function since it is truly placed at the interface of the Hospital and the larger community that it serves, thereby linking the Hospital with the environment (Pfeffer, 1973). It's aim is to obtain resources from the environment as well as act as a buffer between the Victorian Government and the Health Commission on the one hand and the Hospital and its staff on the other.

A real conflict on the matter of staffing occured in 1986 between the Chairman of the Board and the Regional Director of Health at that time. The dispute centred on the appointment of the present Chief Executive Officer who had been selected for the position by the Board with a firm recommendation by its Chairman. The Director, however, felt that the incumbent was unsuitable having chosen someone who he felt was more in line with what was required in the job. The Chairman and Board members then began to lobby the Victorian Hospitals Association and the Australian College of Health Service Administrators.

The whole drama ended in the hands of the Minister of Health, as neither party was willing to compromise. The Director remained adamant about his decision and the Board was fully behind the applicant who happened to be the Assistant Chief Executive Officer of the BBH and was highly recommended by his superior, the Chief Executive Officer. The Board also felt that since it had the right to appoint whoever it saw fit, a decision against its recommendation would set a dangerous precedent with other hospitals, let alone relecting on its lack of power in the decision-making process.

Suffice to say, the Board won the day; the Assistant Chief Executive Officer was appointed and the Director was apparently quite severely reprimanded over the way he had handled the whole affair. A few months later he resigned his position.

This was a typical case where a quick decision had to be made. The strategy used was one of forcing, where the Minister used his superior power to impose an immediate conflict solution resulting in one party the winner and the other the loser. Moreover, it made the winner even more determined to succeed to show the Board that they had in fact made the right decision.

As the Chief Executive Officer explained:

"I've been driven by the devil by the way I've got my appointment and that means proving to people that I can do the job particularly to that past and gone Regional Director who was a real idiot. Above all, I want to prove to the Board, especially the Chairman, and to the VHA that their fight for me was not in vain and that my appointment was the right thing. And finally I want to prove to myself that I can also achieve things that my peers in other hospitals have achieved."

One of the problems facing the Board is that members only attend a few times a month and are also somewhat remote from the underworld of the Hospital where many of the tensions, anxieties and problems reside. It is only after a time when these problems have reached the higher levels of the hierarchy, that they are brought to the attention of the Board where a decision then has to be made.

An example is the problem with the situation in the Operating Theatre Suite. This had become worse by the month and only now after two years it has been put down as a major agenda item requiring the most urgent attention by the Board.

Hospital agreements project

Currently the Board's internal role can be described as a paradoxical or conflicting one. It's internal decision-making authority, like its external functions is subject to continual erosion by increased regulations, health planning, and State budget reviews. The Board's authority, in other words, to set financial goals and policies is being severely constrained by regulations imposed by the Health Department whose main aim is to contain health costs.

On the other hand, however, the Health Department is forcing the Board, through the role of the Chief Executive Officer, to become more active in many areas of decision-making. The BBH has undertaken a Hospital Agreements Project designed to give it more autonomy in its operations, thereby reducing the bureaucratic control by the Department. Various plans have already been shelved because the Hospital cannot deliver due to the continuing financial constraints imposed upon it.

On the issue of bureaucratic control over Board decisions, a Senior Hospital Administrator commented:

> "I wish the Board had more power instead of rubber stamping everything that comes from these bureaucrats in Spring Street. These people have no idea or experience how this hospital functions which seems a great pity. Boards are political appointments which often make them perhaps not as efficient as they could be. The Health Department seems to want to exercise more control although they claim they are not. A hospital like ours should be able to run by itself and stand fair and square on its own feet."

Relations with the Chief Executive Officer

The function of the Board at the BBH is to establish the policies needed to guide the Hospital towards the achievement of its objectives. The execution of these policies is the responsibility of the Chief Executive Officer who is a creature of the Board receiving his authority by delegation from the Board. The increasing complexity of operating the Hospital has become greater and so the Board is giving the Chief Executive Officer more power to run the Hospital on a day-to-day basis. His concerns focus on the administrative decisions relating to funding and inter- departmental relations and co-ordination.

Asking one of the Board members how he perceived the role of the Chief Executive Officer, he replied:

> "It's quite clear to me that Bill has to do what we the Board tell him and yet we depend very much on his advice as to the direction we should take. Let's face it, he's in a powerful position and shouldn't really side with anybody or become, palsy walsy in anyway. When you're the boss you should make that clear to everyone and don't pussy foot around. He should do what is best for the Hospital and its patients and that means projecting an image of strength and independence and a good negotiator and diplomat. Someone who can smooth the waters rather than stir them up. Bill seems to me a little less sure of himself and thus needs to be more assertive. Overall, I think he's doing a good job and deserves the respect of his position."

Generally, the Board limits its activities to the formulation of general policy and doesn't get involved in the detailed supervision of the daily life of the Hospital. The paradox is that on the one hand the Chief Executive Officer wants the Board to be more interested and involved and on the other doesn't particularly like members "meddling" into complaints brought up by staff unless a critical stage has been reached. Consequently, the discretionary power that the Board delegates to the Chief Executive Officer concerns mainly policy matters.

This raises the issue on the sources of internal influence with the Board having the ultimate authority and the power to hire and fire; and the Chief Executive Officer wielding his influence over the Board by being in control of information which he may or may not pass on to the Board (Schulz and Johnson, 1976). Overall, the relation between the Chief Executive Officer and the Board is quite harmonious, and ever since I have been a member on that Board there has been no friction of any kind. One of my main concerns and frustrations is the lack of resources and the

continuous tightening of the budget as Ie indicated in Chapter 8. One feels rather powerless in the decision-making process as the lack of finance influences the whole planning process as well as hampering high quality patient care. It also makes one aware of the constraints under which the Chief Executive Officer has to operate apart from his lack of knowledge and expertise on nursing and, especially, medical matters.

Relations with the medical staff

One of the functions of the Board is to approve the selection of the medical staff and to communicate regularly with the doctors via the medical staff organization. While the medical staff is directly responsible for the quality and scope of medical services in the Hospital, the Board has the ultimate legal responsibility in its role as a corporate body for the acts of its servants. Unlike the Executive and the staff of the Hospital, the medical staff have an indirect relation to the Board.

At the BBH, the medical staff are slowly starting to exercise more formal influence in the operations and services of the Hospital through Board representation and the committee structure. The latter consists of the Joint Consultative Committee, the Patient Care Review Committee, and the Medical Advisory Committee. These committees provide a liaison between the Board, the Executive, and the medical staff and help to establish the authority of policies and procedures that have been agreed upon. Without these formal arrangements, there is no way to establish and to enforce accountability and no way to verify authority.

The status of the medical staff on a day-to-day basis, is one quite independent of the Hospital, the Board, and the Chief Executive Officer. Although the Board has legal responsibility and coercive authority regarding the matter of appointment, in

practice its involvement in medical staff affairs is limited to ratification of proposals and preformed decisions presented to it by the medical staff through the Chairman of the Medical Staff Group or the Medical Superintendent.

When discussing the relation of the Board to the Visiting Medical Staff, one prominent surgeon had this to say:

> "Regrettably, very few members of the Hospital Board have any contact whatsoever with the Visiting Medical Staff and by-and-large many members of the Board are totally unknown to us. I only know a few and that's mainly through heresay. What is needed is for us to be there at their level so that we can at least see the colour of their eyes. Contact and discussion between the two bodies is virtually nil apart from the occasional meetings of the Joint Consultative Committee. We have a gross lack of input even though we have two (two mind you!) doctors on the Board. One is a Paediatrician who rarely attends meetings of the VMS and the other a doctor who was an RMO at this institution and whose hospital experience and knowledge of provisions of hospital services could only be described as negligible. Many of us, including myself, have applied on many occasions to get on the Board believing that we have something to contribute only to have our application turned down. The previous chairman had no drive and was too afraid to make a move. Not that the present one is much better - a milkman running the show; he probably sells milk to the Hospital, it wouldn't surprise me. They're all bloody whimps."

Another Visiting Medical Officer declared:

> "There is always a gap between the medical staff and the administration, including the Board. We would apprec iate being consulted or given a chance to formulate an opinion on most matters within this hospital including

largely administrative matters because so often these effect the working of the medical staff. To my way of thinking there is quite a gap between the Board and the Medical Staff Group. There is no rapport between the Board members and the Medical Staff and decisions taken by the Board have not always been the choice of the Medical Staff Group."

THE EXECUTIVE

As indicated by the Hospital organization chart, the next level of the structure below the Board is that of the Executive. The role of the Executive is influenced by the personalities, values, attitudes and the knowledge and skills of the members. It also depends on the type of hospital and the environmental characteristics. At the BBH it is in the form of a multiple management team or co-ordinated group with the Chief Executive Officer as the chief co-ordinator but a "first among equals" with the other actors, namely the Deputy Chief Executive Officer, the Medical Superintendent, and the Director of Nursing, being something less than equal but more than just subordinates (Rowbottom, 1977). All three key players are responsible to the Board through the Chief Executive Officer. They all serve key roles at the boundary of the organization, between the professionals and other occupations inside and interested parties, such as the Government, Associations etc., on the outside. Each head is able to play a full management role in relation to his or her own division as well as remain professionally autonomous. It seems a fairly adequate mechanism for co-ordination and control although there are slight personality clashes between the parties causing a certain degree of friction now and again.

The role of the Executive basically involves implementing and executing the policies of the Board, reporting back on the degree of success reached, and following guidelines as to the need for modification. The Executive has legitimate authority and some expert power in the relevant disciplinary areas. The ultimate authority however rests with the Board.

THE CHIEF EXECUTIVE OFFICER

The present incumbent is of middle age, has a Bachelor Degree in Health Administration and held the position of Deputy Chief Executive Officer at the BBH for six years prior to being appointed to the top job. The Chief Executive Officer is directly responsible to the Board for the effective management, control, and operation of the Hospital; for the general direction of all business and affairs of the Hospital as a whole; and for advising and making recommendations to the Board with respect to these activities. He is also responsible for the efficient performance of duties by all salaried officers and servants except duties of a purely professional nature performed by medical officers, nursing staff and medical ancillary staff. The Chief Executive Officer has no advisory relation with the Medical Staff let alone administrative authority or any direct enforceable means of control over them. In fact it seems that the Medical Staff are more or less left to their own devices. The only liaison between the Chief Executive Officer and the doctors occurs through the committee structure and what they decide is usually agreed upon, or occasional independent visits to his office to lobby for their cause on some important issue. That is the problem and dilemma with the dual line of authority in the total system that I discussed before.

It is interesting to hear how one of the visiting medical officers perceives the role of the Chief Executive Officer:

> "I really have very little understanding of what the CEO's role is all about. I do know, however, that there are four parties that he has to keep in harmony; and that is the Board, the Medical Staff Group, the Medical Superintendent, and the Nurses through that autocratic new Director of Nursing. To tread the straight and narrow and to keep them all on side is difficult for anybody and most likely impossible. I'm not sure whether our CEO is made of the right fibre to do that. I certainly wish him all the best."

The day-to-day management of the Hospital, resource allocation, co-ordinative decision-making, and the control and management of conflict are shared with the Medical Superintendent, the Director of Nursing and the Deputy Chief Executive Officer. As the Hospital is becoming more complex the role of the Chief Executive Officer is changing. When asked about his role he replied:

> "My role is to serve the community as best as we can within the constraints put upon us. This Hospital can no longer decide what is best in its own right but must operate within the context of a State and Regional health plan. My biggest frustration is dealing with the Health Commission through the Regional Director. There are no trade offs; its all a one way trip. When they ask your advice and you give it they don't do anything anyway having prepared the advice already. It gives me great satisfaction in seeing things getting done. I can't fix a patient but I can create a facility which the patient can get the benefit of. Makes you feel good especially if the decision is really yours alone. I suppose that's edging on the power scope a bit.
>
> So that's one side to my role. The other revolves around teambuilding and the co-ordination of all divisions and staff through the key people. I, like everyone else in my position rely heavily on the advice of my divisional heads; it's a fact of life. I know very little about nursing let alone medical matters. You're only as good as the people or so called experts advising you.
>
> Very often I have to arbitrate, conciliate, guide and even direct; it depends on the situation as it occurs. My most difficult task is to control my senior people and resolve conflicts between them. If there is a disagreement then it depends on the issue; if its

philosophy then it's their view against mine and what difference does it make anyway. If things however really run against the grain then it becomes very difficult and you've got to be so diplomatic. The hardest task is to chastise a division head like the MS DON; I really haven't got that much power. My basic aim is to keep a good working relationship with my senior staff especially the Executive so that we can work in concert. I don't really get involved in problems relating to staff below the divisional heads; the latter can take care of those as the case may arise."

Judging from this comment, the Chief Executive Officer has really several roles to play. He, like the Board, is also to some extent in a boundary spanning position between the professionals and others on the inside and interested parties such as Governmental agencies and professional associations, etc., on the outside. Both the Board and the Chief Executive Officer play a major role in the Hospital's external relations, with the Chief Executive Officer becoming more and more the Hospital's representative to the community.

Within the Hospital the roles of the Chief Executive Officer are basically two-fold. Firstly, he feels directly accountable for the General Services Division through the medium of the senior staff who are his own subordinates in the true sense of the word; for example the Deputy Chief Executive Officer and the various other heads of Engineering, Administration, Finance, Domestic Services, Food Services, Computing and so on. Interestingly enough, as he pointed out himself, his line of authority only extends to those senior positions. This is quite different to the typical bureaucratic structure where authority extends right down to the first line supervisor and it shows once again the uniqueness of the Hospital as an organization. Many of the disturbances that occur below the senior level ar enow handled by

the Deputy Chief Executive Officer leaving the Chief Executive Officer to focus on external and Executive matters.

Secondly, apart from these managerial or superior-subordinate relations within the General Services Division, the Chief Executive Officer's role is that of coordinator and mediator in relation to the Executive and divisions that they represent. It means reaching a compromise between the conflicting goals of the competing parties and balancing with varying degrees of success the power and demands of the various professional groups behind the scenes. In other words, a great deal of the time is spent handling disturbances in the structure (Mintzberg 1979).

In order to carry out these tasks effectively, the Chief Executive Officer requires the authority and power appropriate to his increasing responsibilities. He has a strong sense of achievement, a need for status and recognition, and a desire for a greater share of power. It seems he enjoys playing that game recognizing also the importance of political manoeuvering that goes with it. But his opponents are also powerful, some more than others and so it becomes an exercise in knowing what power is and comprehending its various aspects in order touse it and not abuse it. The skill is knowing what power he has got as it relates to each of the parties concerned. Mintzberg (1979) stresses that the professional administrator keeps his power only as long as the professionals view him to be serving their own interests effectively.

The Chief Executive Officer knows quite well that his power is limited and that what he can do is admittedly less than what he desires. He holds a certain degree of charismatic power but it is the expert power which is becoming a more significant basis of influence (Gordon, 1962; Moore & Wood, 1979).

As he remarked:

"My power base is certainly not coercion and not reward because I can't reward financially although I try my hand occasionally at the psychological approach. I would say that apart from the position I hold, my power is derived from my expertise through experience and knowledge about finance and the administrative side of things. I know my own area well and know that I can do the job. But it's more than that it's having respect for people and showing a personal interest in them. You don't get anywhere talking down to people in our type of organization. I feel most comfortable with my own Division having been there for so many years. There is an intricate understanding between us and I have a fair acceptance of what I say. I know their credibility, how much to trust them and how they measure up. Anyone outside my own area becomes a question of gut feeling."

When asked about his relations with the other members of the Executive and how conflict is handled, the Chief Executive Officer replied:

"Relating to my top colleagues becomes a slightly different ball game. With the Deputy it's a superior-subordinate relationship and thus I use a more directive approach because she is new, but that is slowly changing. She is now also part of the team although some still perceive her as a subordinate. My approach to the MS and the DON is a lateral one because they know their job. Since I know very little about their area of expertise I can't teach them anything and thus they know they're in front anyway. It's a team effort whereby we negotiate and co-operate with me just a whisker above them. It's the only way we can become a harmonious group of four and avoid a lot of the conflict that could occur. My leadership style is thus a very democratic one so that we can all consult each other."

From my vantage point as a researcher, observer and member of the Board, the Chief Executive Officer is developing fairly well in his position of top administrator. He seems to have a fairly good grasp of the necessary technical skills or expert power to operate the Hospital. This together with his legitimate power of the appointed position, which should be recognized as his rightful domain, should be the most effective base in dealing with the Board, the Executive, and the Medical Staff through the various committees.

What should be cultivated more perhaps is the charismatic bit and he should ask himself as to the image he projects and other's reactions to it. He is certainly gregarious enough and flexible in his decisions to be able to work on that particular power base. What is in his favour is the push to prove himself, a dedication to hard work, and a great deal of common sense. Yet, the Chief Executive Officer is well aware that the big stick, top-down leadership approach does not work in the organizational culture in which he operates. What he must develop are the skills in consultation and negotiation. In addition as well as being a good jockey he needs better early warning systems. That is, he needs reliable and experienced staff that spend some of their time scanning the Hospital and Community horizons for potential crisis and conflict. It will give him the required leeway to prepare for the gathering storms even before they break.

The important thing for the Chief Executive Officer is to prevent the various power struggles from getting out of control and to channel them in ways which will benefit the BBH so that the primary task of effective patient care is not lost. Organizational arrangements and mutual understanding must be achieved so that all the major parties are able to release and co-ordinate their talents without unnecessary strain, anxiety, and conflict (Gordon, 1962). Under the present circumstances together with the types of key actors involved in the drama, this goal is still a fair way in the distance.

THE DEPUTY CHIEF EXECUTIVE OFFICER

With the promotion of the Deputy Chief Executive Officer to the top management position, the vacancy was filled by a woman who was formerly employed at the Royal Melbourne Hospital and has had about ten years experience in a similar role. She is responsible to the Chief Executive Officer for the co-ordination and efficient operation of the General Services of the Hospital - Engineering, Food Services, Domestic Services, Communications, Purchasing and Supply, Linen Supply, and Personnel Services. In addition the position requires in assisting the Chief Executive Officer in supervision and organization of the administration of the four small associated hospitals in the region. The Deputy Chief Executive Officer holds a Masters Degree in Health Administration as well as accounting qualifications, which come in useful in assisting the Chief Executive Officer in the direction of the financial affairs of the Hospital.

When questioned about her role she replied:
"It's taken a while to be accepted into the Executive team because some may have thought that my status is not high enough to belong there. I like a team approach because we could all achieve a great deal together. You need respect thought to achieve something. People are fairly hierarchical minded and that's the framework they work in. I just wish we could speak to each other more. It's not only us up here, it permeates throughout the whole hospital. Each division and key individuals within them see things from their own perspective and it's so difficult to get people together to iron out their differences and conflicts. It's always a power struggle with self-interest at the centre of decisions or sticking up for their own rights. People need more conceptual thinking and a systems knowledge."

On the subject of her influence in the Hospital she commented:

> "It's hard to judge how much influence I have. I think my opinions are valued sometimes. There are certain changes I can initiate in my section but anything major is discussed with my superior. There is quite a lot of conflict here and people fight for their individual section. As an administrator I have to sit on the fence and balance things. Each objective is indirectly related to better patient care. We have greater influence on the administrative side but not so with the areas of nursing let alone the medical staff. My biggest frustration is dealing with the Health Department. You become very cynical because of the time wasted regarding uncooperation and continuous reversal of decisions. They have a very strong control over us as far as capital works and the staffing profile is concerned. The finance shortage is frustrating and we end up penny pinching.

THE MEDICAL SUPERINTENDENT

The position of the Medical Superintendent is very much an Australianism. Reading about the medical staff structures of hospitals in Great Britain, the United States, Canada and Western Europe and finds that the position of the Medical Superintendent has almost been abolished.

Articles have been written in Australia based on the question as to whether there is really a need for a Medical Superintendent. However, this is not really a point of issue here. What is interesting is the view held by the Manager of the Royal Melbourne Hospital who states that if there is a need for a Medical Superintendent then some of the following qualities are important:

- good clinical knowledge and judgment
- natural administrative ability
- a good communicator with all levels and classifications of staff
- a sound knowledge of the culture of the hospital
- empathy and integrity
- the courage to implement unpopular decisions
- to be a member of a team

At the BBH, the Medical Superintendent is a Sri-Lankan who has been in that position for over twenty years. He is medically qualified and also holds a Diploma in Health Administration. He is also a member of the AMA and the Association of Medical Superintendents. The Medical Superintendent is responsible to the Chief Executive Officer for the medical administration of the Hospital and for liaison between the Executive and the medical staff. According to the Hospital chart he is directly responsible for the resident medical officers, the salaried medical staff and the medical ancillary (paramedical) staff. Other functions are to monitor policies relating to the efficient utilization of all patient services especially Admissions, Casualty, Outpatients and the Operating Theatre Suite.

On his perception of his power base and role he replied: "My power base is my legal position but I wouldn't put much value on that. The important thing is getting on with people, to be fair, and have some clinical and managerial knowledge. I perceive my role as mainly administrative; some rostering and writing reports. But I also see myself as an information gatherer, general medical problem solver and adviser to the CEO and the Board on medical matters. It's really difficult to pinpoint my actual task and it's only recently that I decided to write out a job description. With the fourth Hospital Accreditation coming up I thought I better not tempt fate and wrote one out (laughter)."

The Medical Superintendent displays a somewhat cynical view towards some of the rules, regulations and committees and prefers to play a more informal role behind the scenes. He is often seen chatting to people in the clinics, the wards, the admissions area and in his office. Although the role of the Medical Superintendent is written up in a job description it has more or less developed on the basis of his own personality and ability, and on the basis of his relations with his role set. The latter constantly brings influence to bear upon him which serves to regulate his behaviour somewhat in accordance with the role expectations they hold for him. Often these expectations conflict but the Medical Superintendent doesn't seem to suffer under any great degree of role strain due to his fairly easy going nature.

On the question of whether he perceives himself as a professional or as a bureaucrat, he replied:

> "It's an interesting question and one that I asked myself during the nursing dispute. My sympathy is with my profession but my first place is with the Hospital. If I had to choose I would stay with the Hospital to which I feel a great attachment and loyalty."

Member of the Executive

As a member of the Executive, the Medical Superintendent confers with the Chief Executive Officer, the Director of Nursing and the Deputy Chief Executive Officer as often as necessary on all matters pertaining to the efficient management of the Hospital. On the nature of these relations he declared:

> "I see myself more in the middle because I can see things from the medical side but can also appreciate things from the administrative point of view. I'm a negotiator between the two frames of reference trying to explain to each group the type of problems that occur on the other side. My opinions are generally valued and I'm often consulted on important medical matters.

Overall, we work quite well together. My relationship with the CEO is good and is purely an advisory one we negotiate and discuss but that's not the way it is shown on the chart. I'm more comfortable with him than with the DON. Her style is different to her predecessor with whom I had far more informal discussions about nursing and medical matters. She works from the premise that nursing is an independent profession and that doctors are not always necessary to decide things. She doesn't see the need for too much discussions and so I'm not going to push it."

Relations with the medical staff

The Medical Superitendent's role vis-a-vis the visiting medical staff is purely advisory and not a supervisory one. For the most part however, the relation remains undefined. He has the responsibility for seeing that facilities and equipment are provided for the visiting medical staff, but has no say regarding the manner in which they are used for patient care. His only power base seems to be his formal position coupled with a certain degree of clinical expertise.

On the relation the Medical Superintendent commented:

"I would say that my relationship with the VMS is a cordial one; that is, we accept each other but that's all. There is no direct authority either way. One of my frustrations with them is that they are so reluctant to fill in forms that go to Labs or X Ray. The nurses are always complaining about that. I have the authority over that. I see a great deal of conflict between them and other groups such as the nurses and some of the paramedical staff, but can't do much about it. Even amongst themselves there is friction. Let's face it, it's a fact of life. Either it's personalities, or people act without consultation or discussion. They

each assume that what they are doing is right and that other people around them will accept that. They are in control of strictly medical matters. The CEO doesn't play a major role in that respect. If I disagree with them on a medical issue, I discuss it with the CEO and bring it to the attention of the Board, which then makes the decision."

It is difficult to say whether the Medical Superintendent is seen as a manager or a clinician. He seems to rest uneasily somewhere between the two camps. Neither the medical staff nor the Executive and the Board are quite sure where he stands.

The visiting medical staff tend to see the role of the Medical Superintendent as purely one of handling routine administrative matters and providing a certain communication link between them and the Executive and Board. He is seen to be undecisive, noncommittal and having little authority to make major decisions or to define the policies of the Hospital. Members of the visiting staff therefore decide issues mainly through the Medical Staff Group, the Patient Care Review Committee and the Joint Consultative Committee. The Medical Superintendent is not a member of the Medical Staff Group and although he is permitted to attend meetings and to enter into discussion, he is not entitled to vote.

A senior surgeon aired his feelings about the Medical Superintendent by saying:

"The man has a negative attitude to most things and is so non-productive with no life in him. What you need around here is someone who will lick people into shape; someone with a whip who is going places."

A physician commented:

"On the surface we have a good working relationship although we know that some of the difficult decisions will never be taken because of the personality of the man; we've come to live with that. Anyway, many of the problems that perhaps could be attended to by the MS are thrashed out by the MS (Medical Staff) Group so that we have some compromise."

A similar and interesting view was taken by another visiting medical officer who declared:

"Val's job is not easy because he's forced to wear too many hats and also has such limited administrative support since there is no Assistant MS position as in many other hospitals. Unfortunately, he's unable to properly represent the VMS as a group. His interests clash between those of the Hospital's needs or objectives and those of the Medical Staff. Also he's not respected because, as always, clinical doctors look down on administrative doctors as is the case in nursing. There is always this informal pecking order. It happens within our own group as well."

One of the senior registrars felt that:

"I'm responsible to the MS on matters of conduct but not the day today clinical things. But I and my colleagues (of ten) have some problems that need his attention but he never seems to make a decision. I don't know whether he finds it difficult to offend people or simply can't decide. Complaints go out but nothing ever comes back. I wish he'd bite the bullet sometimes or simply find out more as to what our needs and problems are."

The function of the Medical Superintendent with the resident medical staff is to see that they abide by the rules and regulations of the Hospital. That is, that they obey the law

under which they are allowed to train and thereby live within a certain standard of behaviour. Most of the junior RMO's seem to hold a certain dutiful respect for the Medical Superintendent which lessens to a certain degree as they climb the satus ladder. They, like the nurses, are also uncertain at times as to whom they owe their allegiance to which can sometimes cause conflict. As far as the clinical task itself is concerned they are under the authority of their clinical superiors, the visiting medical officer's. The question arises as to whether they respect the latter's wishes or do they obey the Medical Superintendent or managerial structure from where they are paid.

Relations with the paramedical staff

In discussing his role in relation to the Paramedical Staff, the Medical Superintendent held that:

> "As far as the Paramedics are concerned I'm somewhat more in charge this time than just on paper. With some areas like the Physiotherapist and the Occupational and Speech Therapist there is more cooperation because the nature of this work and training is similar. It's not so with the Nursing Staff and the Paramedics because they don't quite understand each other's problems. It is a pity that the medical staff generally don't take the time to understand, especially the older ones, what these people have to offer. The fact that they have very intensive theoretical training even in medical matters, such as the study of the brain or physiology in general, are often better then what the doctors receive. Their understandings and capabilities are much more than doctors realize, as is the fact that they can offer so much more to the welfare of the patient. The Paramedics feel that they are not respected and treated in the manner that they should be. They often find themselves working in a vacuum because the doctor hasn't given enough information about the patient. It's usually just

a brief request. This often leads to some conflict and is a big problem. I don't know how we're going to overcome it - it'll be a slow process. I suppose the two camps could get together to work it all out but...."

On the question of how they perceived their superior one of the social workers declared:

"I'm grateful for the support that I'm getting from the Medical Superintendent who I'm responsible to. He has a great load on his shoulder and has no assistance, not even a car to give him a bit of status. You daren't leave your chair behind here before somebody from the administration comes in and takes it away to be used somewhere else. With us the Medical Superintendent is always doing something. He's up and at it without us even having to ask twice. The trouble is he should be more assertive with others, especially the medical staff."

The Chief Physiotherapist, however, has a different view:

"The MS doesn't imspire me in any way. I have written countless memos requesting things or needing help with some problems; very little is done. He only comes to my section when he shows people around. You really have to push for things before you get anywhere. I can talk about my frustrations but that's all - the blinds are up but no one is home."

THE DIRECTOR OF NURSING

The present incumbent arrived in Bendigo early in 1986 from another country town in Victoria to take up the appointment of Director of Nursing from the previous director who had held the position for some fifteen years. She is middle-aged and well qualified in both areas of clinical and administrative nursing. Her responsibility lies with the Board through the Chief Executive

Officer and concerns the organizing, directing, control and supervision of the Nursing Division in order to ensure adequate, safe, and quality nursing care for patients.

As an individual occupying the executive role of a major division, the Director of Nursing finds herself in a unique place in the organizational structure of this Hospital. Not only is she in a boundary position being fired at from all sides of the boundary, but must also recognize and effectively carry out the duality of her role, namely that of administrator as well as that of practising professional.

The chart of the Nursing Division in Figure 8, shows how the position of the Director of Nursing is a diversified role set being influenced by and requiring interaction with various major classes of role senders. (Arndt and Laeger, 1970). Her major contact in terms of time is with the nursing staff that she supervises directly or indirectly including the Deputy Director of Nursing, the two Assistant Directors, the various Area Coordinators, and various unit managers or charge nurses. Another important relation comprises the Chief Executive Officer and other senior colleagues of the Executive, followed by the Medical Staff and the patients.

According to Aydelotte (1974), the Director of Nursing is not an executive in the full sense, nor is she solely a practicing clinical nursing expert. The nature of her work is such that in order to function effectively she must have the knowledge and skills of nursing as well as administrative capabilities. Her energy must be directed toward meeting the responsibilities of both aspects of the role.

When asked about accepting and recognizing the duality of her role, the Director of Nursing held that:

"Nursing administration is changing and the Directorship is becoming more an executive role. Before it was only

nursing at clinical level but now there is more involvement in decision-making at management level and more responsibility for the financial management of the Division. We need to break down that barrier where I am only seen as a professional and not an equal member of the Executive. Don't get me wrong I also see myself as a professional at all times and try to build up the image of nursing as having expertise and the right to an opinion and being involved in decisions that affect nurses. But I'm also an employee and a bureaucrat. There is no conflict there with me. But you can only become a good administrator if you have an understanding of what goes on at the clinical level. And to properly do that you need qualifications which enhance what you've learnt at the clinical level and helps you to become more professional."

As we explained before, the duality often poses an inner conflict for the two types of expertise are not always compatable. It seems that the present Director of Nursing has resolved the twin pressures of the two roles by her preference for administration. This is the choice she has made and it is an area in which she feels she can grow and truly establish herself.

As a team member of the Executive of the BBH, the Director of Nursing's task is to maintain an effective communication link with the members as well as attend meetings of the Board. Moreover, she must also maintain a high standard of nursing care, establishing patient care policy planning and review systems. Finally, she must also perform other managerial functions relating to the management of her Division which comprise personnel, education, cost efficiency and containment, and industrial relations.

When asked about her role in the Hospital, the Director of Nursing replied:

"I see part of my responsibility as an administrator and coordinator of nursing services and to promote that role at the Board level. Other responsibilities revolve around nuring standards, staff development and the financial management of the Nursing Division. As far as my relationship with the Board is concerned I feel quite comfortable in the sense that I can put my point of view forward. However, I think that the medical opinion is taken as more important then any others. They put up a front and everything centres around that. Generally I am given a fair hearing and have the support from the Board. Even so, at times there are some anti-nursing feelings bacause we are seen to be always wanting, and some of us of course are."

On the question of the contact network, she commented:

"The major players I associate with or rotate with are the Chairman of the Board, the CEO, the MS, the Senior Nursing Administrators and the Charge Nurses. My contact at lower level is mainly through staff meetings. I don't feel that the Deputy CEO should be on the same level as I because I don't regard her status and function as such."

This remark by the Director of Nursing then prompted the question about her relations with other members of the Executive, to which she added:

"I think that the Executive could become an excellent forum for planning and decision-making. However, I don't feel that I have as much input at that level as I should have. It is changing somewhat but I still need to be better informed and we should have more regular meetings. My relationship with the CEO is quite good in that we tend to work fairly well together and on an

equal basis. We respect one another and he tries to involve me in all the nursing matters. I would say that overall he makes the ultimate decision and I somewhat accept that because of the system. From time to time, however I get a bit shirty because he is encroaching on my territory but I believe I can say that to him."

On this issue of the interpersonal relations between a Chief Executive Officer and a Director of Nursing, Aydellote(1974) feels that both parties must function together in a climate that promotes cooperation, mutual respect and confidence, trust, and inquiry in order to achieve some of the goals of the Hospital and thereby meet the needs of patients. The setting of such a climate is really in the hands of the Chief Executive Officer and his style of leadership.

The Director of Nursing can only plan and execute nursing programs that support other systems in the Hospital if she has a sound conceptualization of the processes within the total system. Only then can the contribution of the Nursing Division enhance and complement the programs of the Medical and the Support Divisions. This is only possible if the Director of Nursing has access to these divisions and is given the right to speak openly about issues that affect the Hospital as a whole.

The Director of Nursing's relation with the Medical Superintendent is somewhat distant as was indicated earlier and she herself expresses similar sentiments:

"I don't have a lot of contact with the MS but often have the feeling that he feels I push my own professional barrow too much. I see him as a strong ally but feel frustrated because often nothing is done about certain nursing matters where the medical staff insist on interfering where they have absolutely no right to. His relationship with the visiting medical officers is mainly at visiting medical officer meetings

where he does have some input but I don't think that he is a strong force in determining medical policies. However, to be fair to him there are times when I have gone to him and he actually had acted on some important issue. He always projects this quiet nonchalant facade and you don't know where you stand. The pity is that he has no control over the Medical Staff. The power that these people have in this Hospital is far above that of any other hospital I know. It's tradition; they've grown up with it here. In other hospitals the Medical Superintendent is trained in general administration and is not afraid to speak up. He does have strong views at times but is nowhere near as strong as he should be. It is so frustrating because often we are in a real conflict situation, with the doctors and get no support from him. In committee meetings dealing with infection control, for example, the Medical Staff make a statement and from then on everything is clear cut and that's the end of it. If he were more positive and assertive and pushed his proposal to the Board which would then back him, we would get somewhere."

On being asked to elaborate her feelings toward the Medical Staff in general the Director of Nursing became quite angry and was adamant that:

"The Medical Staff generally still see us as handmaidens, especially those of the older school who perceive themselves as superior. As long as nurses are at their beck and call and follow their orders to the nth degree they get on well. I relate to the VMOs through the Patient Care Review Committee and the Joint Consultative Committee. Very rarely do I have any meaningful face to face encounters with them in my office. A few of the older ones are very arrogant and listen only to their own opinion. I can't solve the conflict but I can either retort with a sarcastic remark

or ignore them altogether. There may be some respect for me because of my position but when it comes to the crunch there wouldn't be much support. It's also because I'm a woman. I don't get as many complaints from the younger male nurses as I do from the females who they treat like dirt. They take their frustrations out on the first year kids (Graduate Nurse) in training who are already coping with stressful situations. In Warnambool (the Director of Nursing's previous hospital) such antics would never have been tolerated by the Executive."

Power

The Director of Nursing cannot accomplish her task if she is left powerless and there is friction and conflict between herself and the Medical Services with whom it is essential to have a good working relation. Weisman et al. (1981) suggest that nursing administrators have limited power compared to doctors and the Chief Executive Officer. They point out that research indicates that in several hospitals surveyed, senior staff from the various service divisions agree that nursing's legitimate authority resided in the administration of nursing service but also that nursing was seen as a frequent victim of encroachment by other groups, especially doctors, into tasks in which nursing authority was relevant.

The view held by Shiflett and McFarland (1978) is that because of position, profession, knowledge, and organizational context, the Director of Nursing may utilize all the sources and bases of power, namely legitimate, reward and coercive powers, expert power and referent power. There are also derivative forces of power such as associative power which comes from close alliances with a powerful individual or group; and also power derived from being a lower participant in the hierarchy which means control of resources and techniques which higher status members require.

The authors caution that the Director of Nursing should neither fear nor overdramatize the use of such powers. Overkill in a power conflict risks loss of effectiveness. The Director of Nursing must be aware of the sources and utilization of her power bases. The game must be played with consummate skill and one must remain cautious and politically astute in demonstrating one's power.

The Director of Nursing at the BBH through her position and title has the legitimate power and authority and its derivatives generally recognized in the Hospital. There is also a certain degree of expert power both clinically and administative as we mentioned earlier. As she herself remarks:

> "I hope my power base is expertise but one has to be honest and say that your position has a lot to do with the influence on people. I hope not coercive but reward is o.k. I can't give them monetary gains but suggestions, and then tell them to go ahead. You don't have to have the technical knowledge entirely but you have to know what they're talking about in order to be seen that your credibility is there."

The referent power of the Director of Nursing is somewhat diminished due to her personality which comes across as somewhat hostile and aggressive. This is unfortunate bacause it seems to be a self defence mechanism by a woman who feels slightly insecure and yet has a strong desire to gain power and recognition. Her strong need to be seen as highly assertive is mistakenly perceived as aggressiveness.

These hostile and defensive personality patterns are also limiting her associative power base mainly because of the lack of cooperation from the visiting medical officer's. The lack of communication between the Director of Nursing and the visiting medical officer's leaves a lot to be desired, thereby prohibiting the development of an effective associative power base. Some of

the visiting medical officer's were asked to comment on how they perceived the head of Nursing Division.

According to one of the senior surgeons:
"There is no doubt that much of the malaise of this Hospital is due to the present Matron and morale has reached an all time low. The woman just hasn't got the right personality in that she lacks an outgoing nature. What is needed is a person of superior intellect and great experience. One that can converse with people and get on with the job. What you've got there is a closed order. But don't worry this woman won't ruin my hospital I'll see to that. Her band of Nursing Administrators is just as bad. You know they have a new grey-pink uniform. We call them the Gallahs, they look and chatter just like these birds always do."

Another surgeon held that:
"Before this new DON came on the scene there was a massive amount of goodwill between the Medical Staff and the nurses. Now suddenly there is this anti-doctor compaign going on - You buggers have had it too good for too long, it's now 1987 so watch it. She makes no effort to communicate, rarely comes to the ward and treats her staff like little children. Even the great Napoleon made an effort to inspect his troops and showed respect for them".

In the hospital environment of today, nursing at the hospital level cannot make major or long-range decisions for itself independent of consideration for other divisional wants and needs, and the ever present constraint of funding cuts. The Director of Nursing must contribute towards the major goals of the Hospital and not just build her own empire . But to be effective she must be directly involved in the decision-making process at the top of the heirachy. This is only possible if she is given that

opportunity as well as being to utilize the various power bases at her disposal. So far the situation indicates a constant struggle for the Director of Nursing, but who is, nevertheless, still willing and able to face and fight whatever comes her way.

CHAPTER 10
THE HOSPITAL SERVICES

THE MEDICAL AND DENTAL SERVICES

Overview

I have already discussed the crucial role that the medical staff play in the management and functioning of the BBH. They, together with the nurses, are at the very centre of the Hospital's primary task, namely the operating core, and thus control the functions which surround the Hospital's main reason for existence. Doctors and nurses hold line functions working on the human raw material. Because the Hospital is a treatment institution the medical staff have a central function which gives them the legal right, power, the autonomy, and the control. The BBH is there to treat patients; that is its task. The doctors are the ones who carry out the treatment. Some of the critical things surrounding patients are the doctor's decisions and actions.

The role of the medical staff includes admissions, assessment, specification of treatment, participation in major aspects of treatment, and discharge. They also initiate and introduce new equipment and techniques as well as the development of existing specialities and the introduction of new ones. For these reasons they can be seen as the most important group in the Hospital.

The medical staff are loosely coupled to the total system by the use of such mechanisms as professional committees reporting to the Board, the attendance of medical representatives at Board meetings and by liaison through the Medical Superintendent.

It may be useful to recapitulate very briefly the reasons for the loose medical staff structure operating at the BBH even though a pecking order or power status ranking exists amongst the

staff in general. Firstly, we know that the majority of the medical staff are visiting staff under contract to the Board, who are not in full time attendance at the Hospital, and who derive much of their income from independent private practice outside the institution. Secondly, the medical staff owe considerable allegiance to the professional bodies outside who are responsible for the professional training and the setting of professional standards. Thus the medical staff have the greatest degree of external professionalism to which they are committed and which is backing them up and guiding them in what they can do or can't do. Thirdly, as mentioned before, the medical staff place a high priority on clinical freedom, autonomy, and control in making clinical decisions surrounding their patients. Finally, the medical staff use their unique relations with each patient as a basis for the foundation for patient care in the Hospital. That is, because of the personal, intense, and trusting relation between the doctor and the patient, the latter can mobilize or articulate the Hospital's services and facilities on the patient's behalf. (Grant, 1985).

The organization

The internal composition of the medical staff varies from one hospital to another. The medical staff at the BBH comprise:

6 Consultant Medical Staff (Obstetrics and Gynaecology, Anaesthetics, Radiotherapy, Blood Bank MO, two Chest Clinic Officers, General Surgeon: all visiting staff)
26 Visiting Medical Staff (Specialists)
51 Affiliated Medical Staff (General Practitioners)
11 Affiliated Dental Staff
3 Salaried Medical Officers (the Medical Superintendent, Casualty Superviser and Officer)
Resident Medical Staff
2 Senior Registrars
1 Academic Fellow

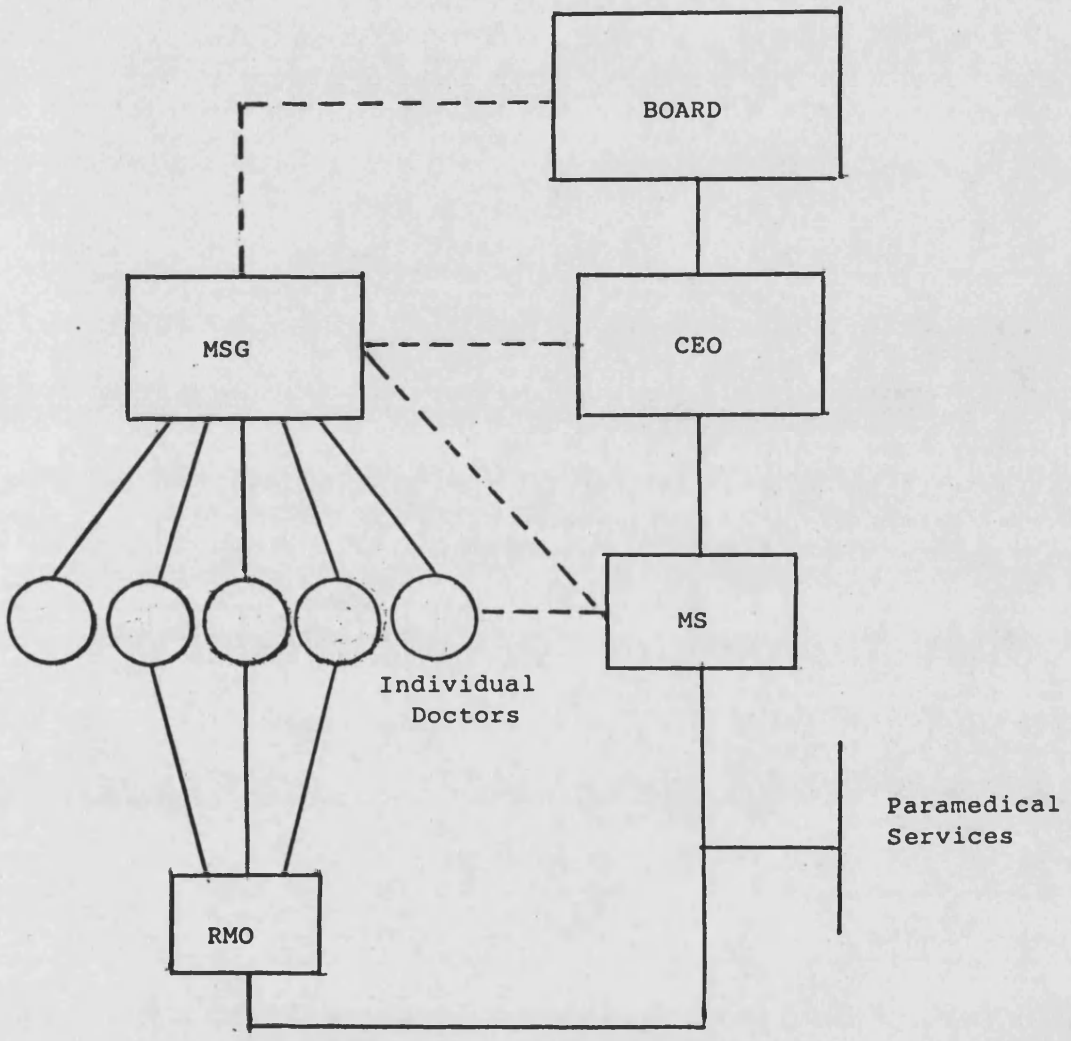
3 Registrars (4th yr)
5 Senior and Junior Residents (2nd/3rd yr)
8 Interns (1st yr)
Dental Staff (3 dentists and a visiting orthodontist)

The medical staff organization in line with the Hospital chart (Figure 5) is depicted graphically in Figure 6. Here the individual trained medical staff are shown to work independently of one another and with little formal organization in carrying out their clinical work. Those grouped together in the same Division or speciality (medicine, general or orthopaedic surgery, obstetrics and gynaecology), tend to work in somewhat loosely organized teams, usually only for the sake of clinical and administrative convenience. Some of the medical staff tend to share the service of resident medical staff, ward areas, the operating theatre suite etc, but do not plan or work together with their colleagues. Although there seems to be some opportunity for informal contact between the visiting staff to discuss matters of clincial interest, time is always against them and the facilities themselves, where one could relax, are not very adequate. In fact under such conditions, the medical staff organization is perceived by many as really existing outside the Hospital.

Medical staff group (MSG)

The Medical Staff Group seems to be the only common meeting ground where the visiting medical staff, including GP's, are able to discuss common problems, lay down certain clinical policies, argue out priorities in allocation of resources and make general recommendations to the Board, the Chief Executive Officer, the Medical Superintendent, or other committees. The Medical Staff Group is regarded as the final arbiter of the collective views of the visiting staff. The individual practitioners are not responsible to the Medical Staff Group, nor has the latter any formal authority over its members. According to the by-laws the Medical Staff Group shall meet at least ten times a year and at

Figure 6. Medical staff organization at the BBH.



——— Administrative
------ Advisory

the Annual General Meeting, the Group elects from among their number the following officers - a Chairman, a Vice Chairman, and a Secretary.

The main role of the Medical Staff Group is really to formulate, plan, and review medical policy. It also serves to represent and protect the interests of the visiting medical staff on issues such as their rights within the Hospital, remuneration, and other medical matters. However, attendances are usually poor and some of the medical staff feel that the Group is overly concerned with medical-political issues and that many of the topics discussed rarely relate to matters involving the improvement of the quality of patient care. Thus its potential of playing a valuable role in assisting with the problems facing the Hospital has been damped.

Ducket et al (1981) also suggests that the close-knit nature of many rural towns provides the scope to lobby which often leads to decisions being made by the most domineering and vocal individuals rather than the visiting medical staff as a whole. This is so true at the BBH where a few key visiting staff members seem to be most influential in the political medical arena. However, now and again certain matters come up, like the situation in the Operating Theatre Suite (see Section D) where the visitors are fairly well united and feel quite strongly about the issue. It is under those circumstances that the Medical Staff Group by virtue of its expert power can be an extremely influential group within the Hospital. It is only when the visiting medical staff is somewhat cohesive that vital issues are sometimes forced out into the open that affect all or some of the various subsystems in the Hospital and it is only then that something is done to settle the conflicts.

All organizations experience divisions of interest in their subsystems. Often differences of opinion are a healthy sign and may lead to rich and rewarding discussion. However, self-interest

relating to medical practice can result in conflict which will then spread to the rest of the Hospital. According to Burling et al (1956) the most disastrous divisions for the welfare of the hospital arise from personality clashes and competition for patients. If the medical staff are themselves conflicted their dealings with other powers, such as the Board and the Executive, are much more difficult. As one surgeon put it:

> "I have a rather negative attitude towards these Paediatricians who never attend MSG meetings and are left-wingers. They send their patients to Melbourne for surgery with no respect for our own ability let alone the concern for the parents. I also don't like these Radiologists ripping off the system. They are paid on a fee for service and not on a sessional basis for public patients like we are. Sure they deserve a certain respect for what they do but it's not a question of life and death that is at stake like in our game. The Board should consider this and put up a strong case to the Health Department, but knowing the Board...."

As I argued in Chapter 6 very few of the visiting medical staff think and address issues organizationally as well as behave as a cohesive group on issues relating to patient care policy. This situation is clearly reflected in the words of one:

> "Although we are still a rather powerful group, our power has been slowly decreasing in this Hospital because we are not politically cohesive and operate mainly on our own accord. Most of us don't work together as a team trying to achieve objectives for the common good of this Hospital but for problems that are specific to us. Here we have fragmentation, disinterest and disillusionment partly because some of my colleagues feel that nobody in the administration is interested in their problems. They quickly forget how well off they have really been for so long. It's a pity because other hospitals seem to have a much more united medical staff

properly qualified ones to be there."

I believe that it is no longer tolerable to leave policy decisions relating to patient care entirely in the hands of the Medical Staff Committees made up of visitors, however well intentioned they may be.

Authority among the medical staff

In an organizational sense and according to the claims of the medical profession, medical staff in the Hospital are basically equal and their authority is based upon their knowledge and experience rather than any position they might hold. They form together what is essentially a large collegiate-structure or coalition (Rowbottom 1977). According to Susser and Watson (1975), this means that the most junior doctor can address the most senior as a colleague and that the professional and ethical obligations of one to the other are fully reciprocated. However, it is observably not the case that there is no authority arising from rank, and that all doctors are equal in power and prestige.

Relations of the visiting medical staff with each other

Although the medical staff at the BBH are peers in the professional sense, some have more power and influence than others. It is a ranking based more on a professional hierarchy than a bureaucratic hierarchy of authority. In the former, influence is used in the relations which exist between doctors and the way in which they exert authority over one another. Goss (1963), who has studied the hierarchical structure in the working relations of doctors in hospitals, describes it as an "advisory bureaucracy". In a formal bureaucratic hierarchy, the ruler and regulations define the exact authority between superior and subordinate.

If we accept that most professions are regarded as having a higher status in relation to other work groups, then we can also apply a status progression within the same occupation or profession (Green, 1974). At the Hospital a hierarchy exists within the company of equals which is based upon formal positions and a fairly strong informal status network. For example, visiting medical officers who are selected to office in the Medical Staff Group (e.g. Chairman, Vice-Chairman, and Secretary) or who hold the title of Consultant in Obstetrics, Consultant in Radiology or Consultant in Anaesthesia, play a more influential role in the system.

There are also some differences in the relative status of the medical staff in different specialities. In larger hospitals general surgeons and general physicians have the greater power base because of the size of the speciality and the fact that it is regarded as the oldest. The BBH is too small in that respect although some of the surgeons (General and Orthopaedic) consider themselves as the elite group which holds the power. There is one particular surgeon who, because of his age, experience and esteem, is labelled "the Aristocrat of the Hospital" and holds a great deal of power. He came to Bendigo in the early sixties and was soon appointed Honorary Surgeon and subsequently Honorary Urologist some years later. Over many years he has been heavily involved in the Medical Staff Group and is often perceived as the main spokesman for the medical staff playing a major role in framing medical policy within the institution.

Division of labour

As we have indicated in the medical profile that exists at the BBH, there is some division of labour among the medical staff which is organized around the different positions which they hold depending on age, experience, and working relations with the Hospital. It is a pecking order of roles an positions so that each doctor is placed in relation to every other. All junior

resident medical staff are graded according to years in training and are under the supervision of one or more visitors. The grade also reflects the type of clinical work carried out and the degree of responsibility relating to the care of the patient. On a clinical basis the relation between the visitor and the resident is more a superior-subordinate one; whereas the relation between the Registrar and the Intern is more in the nature of a supervisory one. The former has the authority to prescribe work to the latter but has really no right to sanction. At the BBH, the induction of the newcomer to the medical staff is fairly informal.

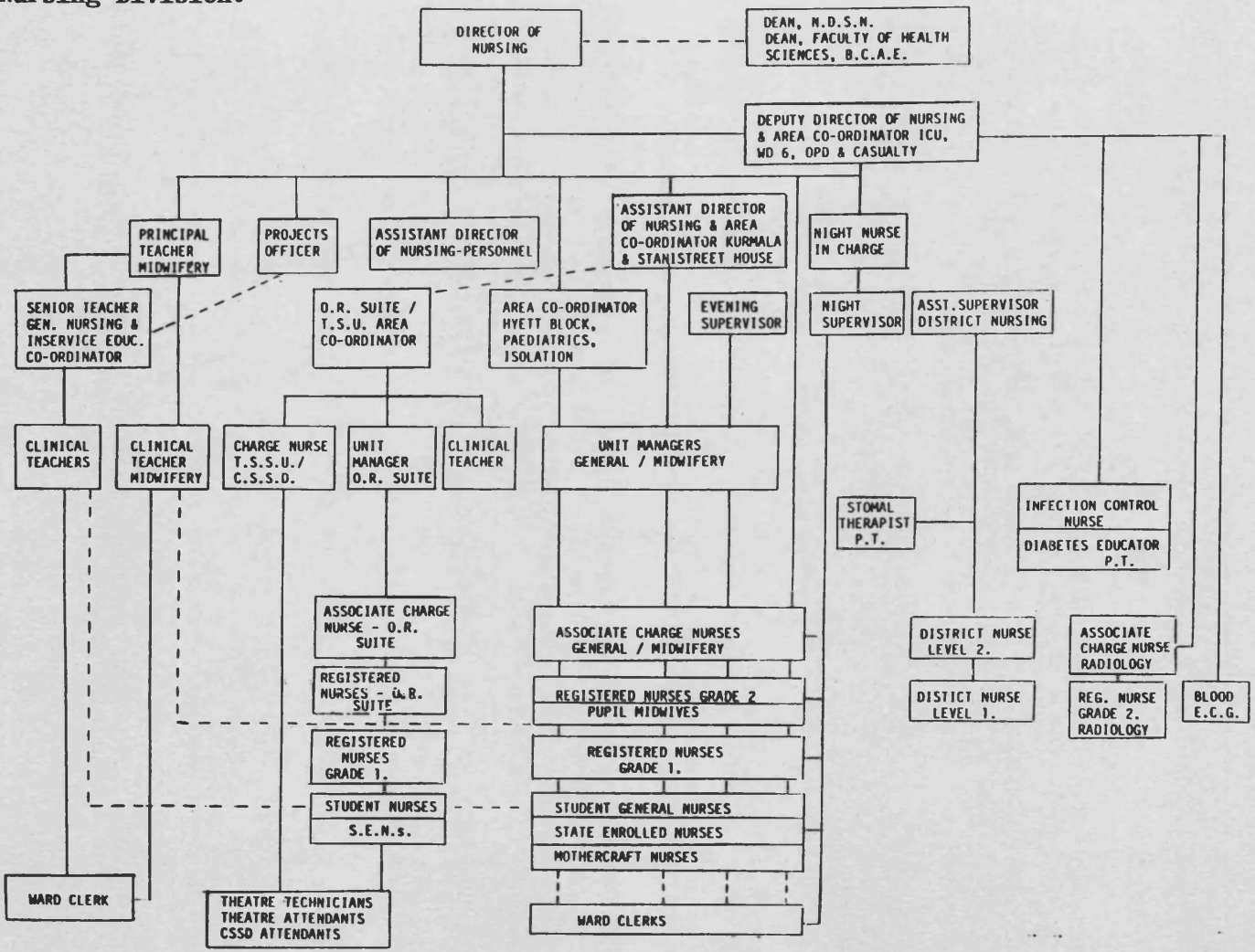
It is under the close supervision of the a visitor or Registrar that the newcomer acquires the necessary knowledge and skills which are perhaps the most obvious characterisitics of postgraduate training (see Chapter 5). Coe (1970) points out that the period of residency is important to the internalization of the attributes of the doctor's role and plays a crucial role in moulding and influencing his or her entire professional life. It is also a period of conflict and anxiety because this trainee is much dependent on others for guidance and support.

THE NURSING DIVISION

The main objective and responsibility of the Nursing Division at the BBH is to provide high quality patient care. Nursing services are also line functions working on the human raw material and are even more central and crucial to the operating care of the Hospital than the medical staff. The nursing staff have the difficult but important function of implementing much of the treatment regime prescribed by the medical practitioners and of coordinating the "cure" and "care" activities of the Hospital. In addition, the Division plays a vital role in maintaining the stability and continuity of patient care and to provide continuing and post-graduate education of nurses. In order to gain a better understanding and appreciation of the role of the Nursing Division the reader should also take note of the various issues relating to nursing as a profession as discussed in Chapter 5.

The Nursing Division employs the largest number of personnel comprising approximately fify-five percent of the total work force. The nurses thus form the largest disciplinary group or major "professional" subsystem which has been termed the hub of the Hospital. Heydebrand (1973) considers the degree of professionalization in the Hospital as measured by the relative size of the professional nursing component, that is, the proportion of registered nurses of the total Hospital personnel. The conflicting nature of the nurse's position has already been mentioned whereby on the one hand, she or he is a full time member of the bureaucracy who reports in the hierarchy through a Unit Manager (Charge Nurse), Area Coordinator, and Director of Nursing to the Chief Executive Officer, (see Figure 7). On the other hand, she or he comes under the control of the medical staff relating to the treatment of the patient.

Figure 7. The Nursing Division.



At the Hospital, nursing staff are slowly moving away from the concept of "doctor's handmaidens" toward more specialized and technical functions. The more specialized the nurse becomes the more the relatively high status differential between doctor and nurses is decreasing. It seems that at the higher level the relation is more of a liaison type or "right-hand man" (Hughes 1958) function, rather than a superior-subordinate one. There is no doubt that at the Hospital the Nursing Administration is pushing for more participatory management, greater equity in power relations and more influence in decisions about patient care and Nursing Division issues.

Composition of the nursing work force

The quality of patient care depends not only on the number of nurses provided but also on the versatility of the staff; that is, on the mix of knowledge, skill and experience available. The Nursing Division of the BBH includes the following nurse categories - Registered Nurse, Student of Nursing, State Enrolled Nurse, Mothercraft Nurse, and Dental Nurse. (Committee of Enquiry into Nursing in Victoria, 1985)

The Registered Nurse (RN). This category is the keystone of the Nursing Division as all senior positions from Director of Nursing down to Unit Manager must be filled by registered nurses. The RN has direct responsibility for translating the prescription of a series of orders into actual patient care and for supervising and training other nurse categories. The educational program for the RN consists of three years theoretical education and related clinical experience.

The State Enrolled Nurse (SEN). According to the Committee, the SEN must have completed a one year program of theory and practice, or have undertaken at least phase one of the program for RN's. The SEN performs nursing functions in accordance with the training received and the level of competence achieved.

Students of Nursing. These nurses undertake a prescribed educational program to become a RN and may be in first, second, or third year while part of the workforce providing a wide range of knowledge and experience.

Other nurses. Mothercraft nurses and dental nurses have limited roles. The mothercraft nurses care for mothers and babies in the Midwifery Unit and the Children's Ward. Dental nurses provide care in the Dental Clinic only.

Areas of activity

Although the nursing staff at the BBH work within the guidelines that are set for them by the medical staff, it is misleading to see them as a homogeneous group in terms of the skills and activities which they use. That is, there are variations in which the prescriptions of a series of orders are turned into actual care and observation (Grant, 1985).

The technical skill. With the significant changes over the years in the technology of patient care processes, nursing staff have become increasingly specialized and professional. The technical component of nursing is reflected in its most developed form in the role of the specialist nurse in such specialized units as the operating theatre, intensive cre, coronary care, and premature baby care.

Basic nurse functions. Due to illness the patient may be unable to carry out normal personal functions. Such basic functions as bedmaking, personal toilet and hygiene, the feeding process and so on, are thus often carried out by lower qualified nursing staff.

Emotional involvement and morale. Another important nursing activity is that of meeting the patient's emotional needs. It is a function which most patients need especially those with acute

and chronic illness as in the area of gynaecology where some cases involve abortions or miscarriages. It is the nurse who has been allocated this task, who, rather than the doctor spends most time with patients and has to be particularly strong to stand up to the emotional trauma that this work entails.

Participation in decisions. There are differences between specialities in the way that the nursing staff interact with the medical staff in deciding about, and giving, treatment to patients (Green 1974). An example could be made between surgery and medicine. Surgical cases in the ward are usually fairly cut and dry where the major emphasis is upon the surgeon whose action depends largely on the patient's complaints and the scalpel becomes the major solution to the patient's problems. Surgeons can see results and are able to cure.

In the medical ward there are patients whose illness often take a long time such as respiratory complaints, heart ailments or other internal problems. In such cases the physician is more dependent upon the continuous observation and monitoring of the patient's condition which is provided by the nursing staff.

It is the quality of nursing care provided by the staff together with the frequency, intimacy, and length of contact with the patient which imparts to the public, more than anything else the atmosphere and repute of the institution. It is the patient's perception of the nursing service provided which plays the major role in branding the Hospital's standing within its community. To the patient, the nurse is the primary representative of the Hospital.

Pivotal role and importance

The important function of nursing is partly due to its central role in providing inpatient care in these various activities mentioned above (Merton 1957). Inpatient care is

basically a team effort involving the medical staff, the medical ancillary staff, nursing personnel and various support staff such as ward clerk, domestic staff, and catering staff.

Being in closest and most frequent contact with the patient, the nurse occupies a pivotal role in this team demanding both professional and inter-personal skills. Grant (1985:103) regards the bureaucratic structure for nursing services as

> "a form of disciplinary defence by an embattled emerging profession against three-sided attacks by the doctors, the bureaucracy, and the newer disciplines ..... compounded by traditional stereotypes of gender roles."

Nevertheless, the nursing staff are beginning to play quite an important role in the group dynamics of the BBH. After all, not only are they becoming more professionalized, but their full time association with the Hospital, their familiarity with rules and procedures, their pivotal position and their ability to develop informal relations with other players, all add up to their slowly becoming a more central force of informal influence throughout the Hospital.

The professional nurse plays a crucial role in the process of coordination by feedback in the ward. This is done by virtue of integrating professional and administrative functions together in one role. Whereas the Nursing Administration staff are more concerned with formal line administrative functions, the joint professional and organizational status of the lower-level staff nurse constrains her to assume coordinating functions which exceed the normal work duties as listed in the job description. Thus while the professional nurse is under formal (line) authority in her nursing function and under doctor's orders in her clinical function, she exercises a considerable amount of discretion with respect to her pivotal role. These functions constitute a relatively independent realm of decision-making and delegation of authority laterally or downward to lower-level staff. If the

Nursing Division were not so conflicted within itself, its potential power and influence would be even greater.

> As one of the senior registrars remarked:
> "I really think that the power here lies with the nursing staff. They have the power over the medical staff because they are the ones who decide how they are going to carry out our directions. They are the ones who give this Hospital its image and the ones who are most in contact with the patient. We couldn't work here without them and are therefore completely dependent on them. My colleagues won't accept that in the real sense but it's true. Some Charge Nurses are very clever in letting some of us believe we have made the decision on certain matters relating to the patient, but it's really their knowledge about the patient which provides them with that know-how. The trouble is, each division is interested in building up their own power base and are not particularly concerned about each other."

The administration of the Division

Looking at the Nursing Division in Figure 7 indicates a clear example of a bureaucratic structure where the use of legitimate authority provides the major power base. The Division is headed by the Director of Nursing and is organized on strictly hierarchial lines or levels. A Deputy Directory of Nursing (and Area Coordinator), two Assistant Directors of Nursing (one acting as Area Coordinator) and another Area Coordinator, all registered nurses, are the next level down and directly responsible to the Director of Nursing. The Area Coordinators are in charge of a particular section of the Nursing Division, comprising group of wards and units related by territory or by function, each one under the control of a Charge Nurse. These are the Hyett Block (Male and Female Surgical Wards, Male and Female Medical Wards, the Children's Ward, and the Isolation Unit); the Kurmala Wing

(private surgical and medical wards) and Stanistreet House (Midwifery Units); and the Area comprising the Intensive care Unit, Cardiac Unit, Outpatients Clinics and Casualty.

Area Coordinators

The Area Coordinators are responsible for the overall coordination of nursing services and resources, which includes the monitoring and maintaining the standard of patient care within the assigned clinical areas by conducting ward rounds, supervising, assisting and advising ward staff in matters of ward management, public relations and interdepartmental communications.

When asked to explain her role in the Division, one of the new and younger area coordinators declared:

> "We are slowly getting more streamlined whereas before it was just kangaroo hopping. Most of my time is spent coordinating and monitoring to ensure that high quality nursing care is provided. I also get involved in long term planning, attending meetings, and dealing with patient and staff problems. The latter have to be handled with great delicacy as some of the girls become quite emotional and aggressive and then after a day or so the logic sets in. Each ward or Unit I deal with is different, with regard to the type of patients, the versatility of the staff and the problems they face, the degree of teamwork and productivity that takes place, and the atmosphere in general. A great deal depends on the structure of the unit and the personality and calibre of the Charge Nurse. The Charge Nurses are my power base and I need their support. They themselves hold the power in the ward and are seen as the unofficial leaders. They are a strong and volatile group here and you have to be careful how you approach them because there is a lot of conflict with some of

them and the Administration. It's a typical them and us syndrome. If you are not diplomatic enough they get very upset and respond accordingly. Most of them have been very clinically oriented and now the change of administrative tasks is taking place which some are finding difficult or don't fully accept as part of their role."

On the question of which skills were most desirable to be effective in such a position, her response was:

"Good management skills are very necessary in my job and you need good management qualifications these days to progress up the hierarchy. Also clinical knowledge is very necesary although I'm a bit rusty there. But it's important and you've go to make the effort of keeping up to date. Nursing education has its place I suppose in giving you a sound theoretical grounding. But it's the basic practical clinical knowledge and skill that will be lacking. You've got to get down to the nitty-gritty stuff. You also have to be public relations oriented and acquire a broader view of things. Ward people are very daily oriented whereas I need a far sighted orientation. I don't think I'm a typical BBH Nurse Administrator - I don't play the lady bit but find I have to be more forceful and assertive if necessary. But you can do that in an informal way which I feel most comfortable with."

Another Area Coordinator of the older school who will retire next year held the view that:

"Nursing attitudes and ideas are changing and so quickly. Nurses today are not prepared to give as much as they used to. There is no give and take any more. Everyone is so conscious of their rights, and self-interest seems to be the norm for the people. There doesn't seem to be any respect. It's a lonely job

being an administrator and most of my colleagues feel like that. You have to use diplomacy, a democratic style of leadership, and friendliness to get on with the lower ranks and yet still be that tiny bit above the others."

Regarding her relations with the medical staff she said:

"Look we all know that some of the doctors here are prima donnas and think they are God's gift to the place but then why shouldn't they be powerful. I've been brought up with that school of looking up and I can't break away from that. In some areas the Charge Nurse doesn't even go on ward rounds any more. I disagree with them very strongly because it's important for the sake of the patient. The doctor then raves and rants because he is upset and is then branded as arrogant. In most of my areas the girls go with the doctor; it's only common courtesy and etiquette."

Another area coordinator, however, perceived the medical staff in a different light when she said:

"One of the weaknesses of this Hospital is that too much power is in too few hands namely the medical staff. They run it for their own benefit to make money and thus don't want change in any way because it means less dollars. They also feel threatened in loosing their authority and status. They don't want to see us qualify or become more professional because it's against their self-interest. The previous CEO was for too easy going with them. He knew what games where being played but had very little power to do anything. People tow the line with them because they feel that only the doctor knows what's going on. It's something that is going to change, it has to."

On the question of how the medical staff generally relate to the nursing personnel on the ward the Area Coordinator held that:

> "Their personality affects the way they work with the nursing staff. Personality and technical expertise play a big role. If there is repsect and understanding between a Charge Nurse and the doctors then there is good cooperation. You don't respect them if there is no patient contact. It's the exception to the rule that the doctor is technically competent as well as having the charisma to be able to relate well to both patients and nursing staff. The information that passes back and forward between the doctors and the Charge Nurse about a patient depends a lot on the relation between the two, which often takes a long time to build up."

The Night Supervisor

Finally, with regard to the administration of nursing services it is important to mention the vital role of the Night Supervisor who is really the de facto Chief Executive Officer outside normal working hours. Her task is to ensure proper nursing care and to supervise and provide support to all levels of nursing staff on night duty as well as being able to cope with major problems or emergencies that arise.

During an interview late one night, she explained her role in the Hospital:

> "I'm in complete charge here from 10.40 p.m. to 7.15 a.m. in the morning and all the night staff are legally responsible to me. It's a strange role in a way because you are quite isolated. They tell you that you belong to Nursing Administration but we are not really regarded as part of a team and are often thought of as not quite so competent. Some even say that we should come on duty during the day so that we can brush up and really learn something. But it's really us who know how a Hospital

works. The day administration spend most of their time in their glass boxes. We know exactly what happens on the wards and are not removed from clinical reality. The nursing staff during the day have very little respect for the Administration who seem to be out of touch with many things. There is not much communication with the day people because they'd only point the finger at you if something goes wrong. There is really nobody to confide in. It's catching up with people, that's the problem, especially in discussing administrative matters. Meetings are held when most of us want to go off duty. This timing business is always a problem and so we often miss out on important information."

When asked about the difference in the atmosphere in the Hospital compared to the day she smiled and replied:

"We have a good atmosphere here becausethe group is cooperative and fairly cohesive. We are a staff and not Ward 1 or 2 or 3 as it is during the day. We mix more and each grade blends together better and respect each other because we are a smaller community. No one breathes down your neck and I think I have a good rapport with my people and they feel secure with me. They are not afraid to talk to me because my opinions are valued. At night we can care for patients without the constant interruption that you get during the day such as from phones, doctors rounds and visitors. Clinical assessment is therefore more in our lap because the medical staff don't always come so readily. There is also no relation with the Paramedics except Ambulance and Radiography."

Here again we have a situation where the various factors such as working hours, personality differences, ad the difference in atmosphere are creating another split in this major subsystem.

Nursing education

The BBH, like many other hospitals cater to the needs for continuing and postgraduate education aimed at improving nurses' knowledge, attitudes and skills in relation to curent developments. The in-service post-basic certificate programs provide nurses with the higher education and superior skills considered necessary or desirable in the various clinical areas. These programs are generally approved by the Victorian Nursing Council.

As Figure 7 indicates, the nursing education area is split into two groups, namely the education in midwifery as well as general nursing and in-service education. The basic aim of the Principal Nurse Educator (Midwifery) is to ensure that student midwives receive training of the highest quality. When discussing her role in the Hospital she said:

> "My job is the academic side of midwifery training and monitoring that the practical side is taken care of by relating with the Charge Nurse. There has to be a close liaison with the Charge Nurse if the education is going to be effective. I check on things but for the department to survive I must allow the Charge Nurse autonomy. They really don't see me as an equal because there is a barrier to being an educator and some see you as a threat stepping into their territory. I think they respect my knowledge though because I've been a charge nurse and a midwife for many years. Because I'm not so much on the ward, the Charge Nurses feel I'm not so practical. I wish I could spend more time there but have other things to do. Educators are alays perceived as a bit of a laugh and people do wonder what we do all day. Why don't they come and check it out for themselves. Even my colleague in general nursing education does not regard me as an equal. It's rather lonely here because we are separate from the general area of training although our room is next door."

When asked about the medical staff the Principal Nurse Educator (Midwifery) replied:

"The Obstetricians see midwives as nurses and handmaidens and always point out that they are in charge of the ward. Paediatricians also see it that way. Perhaps they all feel threatened that's what it seems to me. Here in Bendigo these gentlemen think they are above us all and put themselves on a high pedistal. If I query things they put you down and make you feel downgraded. Midwives should be regarded as professionals and not the doctor's domestic nurse. Because they are ousiders and come to the Hospital they automatically see pregnancy as an illness. It's called stress if the woman doesn't delive according to their formular because they just find it so difficult to put their hands behind their back and let mum get on with it."

On the education process itself, she smiled and said: "You know I have a bit of a conflict because I have to teach a utopian kind of course. I tell them things with blinkers on because my job is to get students through the exam because I get certain guidelines as to how the girls are to be assessed. The reality is out there in the ward because mother's don't believe like they do in the textbook; each one is an individual and each relationship is unique. A good midwife has to have affinity to a woman. We are talking of knowledge about a normal birth. It's only when things go wrong that the Obstetrician should take over. My many years as a midwife have helped me to be able to relate a situation that I've explained myself. I've been there and done that. Teaching is hard work. It's not just a question of learning from books; you've got to be able to pick up the human element which is so important."

It is interesting to note that very similar sentiments were also expressed by the senior teacher in general nursing:

> "Our job is somewhat delicate because the Sister is responsible to the Charge Nurse but we have the function of supervising the clinical aspect and this often causes friction. Although the ward is the domain of the Charge Nurse they don't treat you as their equal. In fact I'm above them but have to go by their rules. It's hard and get's one often very uptight but I can't tell them what to do with the trainee. They have no idea of what it takes to be a teacher and see me as a tutor with not much to do. Because I'm not always there where the action is doesn't mean I don't understand the problems. I'm also short of staff and can't give the clinical time that is required. We seem to be on a limb and and not recognized as part of either nursing administration nor the clinical side areas. Each group regard themselves as superior to the other."

These comments again speak for themselves. Not only do we find factionalism within the Department but there is also friction between the Nurse Educator and the Charge Nurse. It leaves the nursing trainee in the same situation as the registered nurse, namely under a dual influence system. Generally, it seems that the authority of the Charge Nurse tends to have the greater influence on the trainee.

MEDICAL ANCILLARY DEPARTMENTS

The operating core of the Hospital encompasses the medical and nursing staff - the operators who perform the primary task which is working on the (human) raw material. Most of the other specialized areas such as the paramedical staff and the general services personnel exist to provide support to the core activities. This is the support staff consisting of various support units which are more or less self-contained; they are subsystems or mini-organizations.

The problem arises because of the need for coordination between the operating core and the support staff. For example, by giving the orders, the medical staff catches the medical ancillary departments between a dual influence system; that is, between two systems of power pulling in different ways, the vertical power of line authority, and the horizontal power of professional expertise.

The paramedical staff in the BBH have several common characteristics and may be defined as those groups of workers who are directly concerned with the diagnosis or treatment of patients. Here we find acknowledged professions, emerging professions and various scientific and technical occupations. This group includes the following departments: Pharmacy, Medical Records, Medical Imaging, Physiotherapy, Social Work, Sexual Assault, Speech Pathology, Occupational Therapy, Medical Library and Diabetics. Many of these departments are very small and organized in a distinctly hierarchical way. Most of the personnel are female reflecting lower status and lower paid jobs.

According to Rowbottom (1977), two issues continuously come to the fore; namely the lack of clarity as to who, if anyone, is really accountable for the work of the paramedical staff and the lack of clarity in some cases about the authority of the medical staff in relation to the activities of the paramedical staff.

Perhaps more than any other group in the Hospital they tend to "float" organizationally. One could perceive them as being clinically accountable to the medical staff and administratively to the Medical Superintendent and ultimately the Chief Executive Officer.

What basically distinguishes paramedical staff from the medical staff is their relative lack of autonomy and responsibility apart from what is delegated by the medical staff. As a result, they seem to have limited authority. Because of this, the group is often left out of many important policy decisions and their development is thereby reduced. As with nursing, there is a continual attempt on the part of the paramedical personnel to improve their prestige and status in the Hospital through college based education and the formation of associations. The development of this knowledge and skills is moving at least parts of their spheres of competence towards that of the medical profession; but there is still a long way to go.

To provide some examples of how the paramedical staff function in the Hospital, I have selected the departments of pharmacy, physiotherapy and social work.

Pharmacy

The pharmacy service can be easily identified with direct patient care and makes quite a significant contribution towards this task. It is basically in business to provide the drugs and various surgical items that the medical staff prescribe (and the nursing personnel apply) in the treatment of patients. The Pharmacy Department is mainly involved in making up the prescriptions which are ordered by the medical staff and in controlling the ordering storage, and usage of drugs. The latter is important because of the need to comply with the various legal requirements and to control the financial aspects of the service due to the high costs involved. In addition, the pharmacy

service is there to provide expert advice to medical and nursing staff on the pharmaceutical and pharmacological properties and characteristics of drugs.

The drug distribution system in the Hospital is a combination of the ward stock system and individual prescription. With the ward stock system for impatients, the ward drug cupboard in each nursing unit is stocked by the charge nurse and looks like a miniature pharmacy. It is from there that the nursing staff draw their supplies for the medication of the various patients. This is supplemented by individual prescriptions for less common requirements which are despatched to the ward.

Senior nursing staff are responsible for administering the drug to the patient and if this is to function smoothly, there must be team work between the medical staff, nursing staff and the pharmacist if mistakes are to be prevented. Generally, pharmacy tasks are largely dictated by the medical profession.

Overall, policies for the operation of the Pharmacy Department are set by the Board on the advice of the Medical Superintendent, the Drug Advisory Committee and the Patient Care Review Committee. The Department is hierarchically organized under the control of the Chief Pharmacist (who is responsible to the Medical Superintendent), the Deputy Chief Pharmacist, three other qualified pharmacy personnel, one secretary, and two porter-storemen down the line.

When asked to elaborate on his role the Chief Pharmacist replied:

> "A big part of my job involves the dispensing of drugs and providing, where necessary, the uses and abuses of some of these drugs. I'm also responsible for the organization of my department and to ensure that adequate and competent qualified staff are employed. We are somewhat short of staff because attracting people of

high professional calibre to the country is very difficult. We have some good people in this department but we're a little community working in a vacuum because we get very little direction from the top. My biggest frustration is the lack of feedback that we get about the day to day running of the Hospital such as the number of patiens, operations, births and so on. All these things are important in order to control my stock of drugs and surgical equipment. The latter is really not my responsibility and should be handled by a proper purchasing department which we haven't got. A lot of my time is taken up with sales representatives and it's frustrating because we really don't know who is responsible as to what to purchase."

On the question of responsibility he then spelled out his sentiments regarding the medical staff:

"The doctors see this Hospital as complying to their needs and convenience. We are all here to do their bidding, especially nursing. They always want more than the administration can provide and because they are patient oriented they have no respect or interest in the cost of things. You can still be patient oriented like myself and yet be cost conscious at the same time. The trouble is that they prescribe and give guidelines as to what I must purchase and I can't really tell them not to. Also they often bypass me and go to the Medical Superintendent. If it's good enough for me to go through the right channels it's good enough for them to stick to the proper routines and regulations of the Hospital because its really in the best interests of the patient. I haven't got the power base to argue; the doctors have. I don't communicate with some of them anymore they are so arrogant. Some are never satisfied with what I make up for them and others order supplies on their own bat irrespective of whether we are over

budget or not. There should be a much beter spirit of cooperation between us but that's utopia. It's us against them with continuous conflict simmering underneath the surface and on top. Nothing is done about it all, because either the people are too busy or not assertive enough or have given up to caring."

Physiotherapy

Physiotherapy, as an organized and accepted profession, is of relatively recent origin and has now reached a higher status because of tertiary education and training. The occupation is that branch of medicine in which qualified physiotherapists use physical therapy in the treatment of patients making an important contribution towards their rehabilitation. Like with pharmacy, the objectives are aimed at aiding the doctor care for the patient. The care given, enables the patient to overcome any physical disability in order to accelerate his or her recovery rate and reduce the number of days spent in the Hospital. The methods and techniques employed by a physiotherapist to accomplish these tasks consist of the application of electromagnetic radiations, massage, manipulative procedures, splinting and planned exercises.

Physiotherapists are invariably called in by the medical staff in cases where patients require their knowledge and skills. Very often they also make their own ward rounds making various tests and measurements on patients to ascertain the severity or to monitor the progress of disabilities which the doctor may not be aware of. A great deal of their time is spent with surgical patients, ante and post-natal classes and children.

At the BBH, the Physiotherapy Department is in a pivotal position relating to outside organizations and various other units and personnel within the Hospital. The Department is in liaison with the Bendigo Home and Hospital for the Aged;

coordinating its service with the smaller subsidiary country hospitals; providing out-patient as well as in-patient physiotherapy; co-ordinating the ante-natal education program in liaison with the Midwifery Department; and to liase with medical, nursing and other paramedical staff.

For the Physiotherapist to be fully utilized, there must be a build up of good relations within the team and the development of effective working arrangements with the medical staff and the ward nursing staff. Good communication is therefore very important as well as rapport betwen the members. This should be encouraged by the Charge Nurse by her example in showing an interest in the Physiotherapists contribution to the patient's treatment. The attitude of the team members is significant because if they show that they believe in the value of this treatment, the patients will most likely make a greater effort to respond to it (Perry, 1978).

The Physiotherapy Department is headed by the Chief Physiotherapist who is administratively responsible to the Medical Superintendent, coordinates with the Chief Executive Officer on budget matters, and is under the control of the visiting and resident medical staff and associated general paractitioners for the therapeutic treatment of their patients. There are also five other physiotherapists, an assistant and a receptionist. The function of the Chief Physiotherapist is to be responsible for the quality of patient care delivered by the Department, by ensuring that the Department runs in an efficient, well-managed, cost-effective manner, and that staff are committed to their roles within the Hospital system. At the interview the Chief Physiotherapist was very deflated:

> "I feel really down at the moment and have for some time because I'm squeezed in a corner. We have so many cases on our hands both inside and outside the Hospital but the shortage of staff and facilities is deplorable. It is so difficult to attract more staff here because of

the lack of everything. There is also no interest by management to retain staff. There is a high staff turnover because there are no prospects for upgrading. There is no wheelchair toilet, no waiting room facilities and no staff room. Even my office is used as a storage area. So, the quality suffers because of the demand and the lack of funding. It really frustrates me because it drags down my professional reputation as my staff tend to make mistakes which then is put on me. Also not everybody sees me as a professional although at times I'm treated as a team member and my opinions are valued."

On the question of whether he was accountable to the medical staff and whether they coordinate with him, the Chief Physiotherapist replied:

"Some of the medical staff ask me questions and we then negotiate about the treatment of a particular patient. But often I wish people would just let me get on with what I myself think is best. The other day I decided to refer a patient to my colleague, the Occupational Therapist and the VMO immediately took exception and complained to the MS who then came to see me. I just ignore it because he won't do anything anyway. None of these people in pire me in anyway. But some doctors are arrogant and pompous and are not in the least physiotherapeutic inclined. They like to play God and the high professional. One even had the gall the other day to tap one of my senior staff on the shoulders who was writing a report and told her to move while he sat down. There is no respect for anyone else. They don't even both to read my recommendations and they never attend our paramedical staff meetings. Not one medical staff member is ever there, not even the RMO's let alone the high and almighty VMS. It's below their dignity."

When asked about the Hospital in general he felt:
"I'm quite happy within myself as to being able to do a good job both professionally and clinically. You know, nobody ever evaluates me and so I really don't know what they think of my performance. No one seems interested in staff development and it contributes to low morale. Also there is very little feedback in the place as to what is going on. The Hospital needs people who are prepared to make tough decisions but it won't happen because no one is prepared to change or upset the apple cart. I think I might leave soon."

The Chief Physiotherapist has resigned and is now employed at the private hospital, Mt. Alvernia.

Social work

Social workers in the Hospital are there to help patients and their families with the variety of social and personal problems that often accompany disability and illness. The function of the service are to investigate and help patients to regain their emotional equilibrium as well as to develop social service programs in the Hospital and the community. Thus the service provides a direct link between the BBH and its community.

Green (1974) suggests that there is a role conflict in that the medical staff tend to see social workers as more community oriented such as the arrangements for convalescence after treatment has ended, and checking on the financial situation and the family while the patient is in hospital. On the other hand, social workers tend to perceive these tasks as peripheral to their most important job, which they view as helping patients adapt to the emotional and mental anguish that illness and disease can cause.

Very often it is the charge nurse who will refer the patient to the social worker which requires an appreciation and understanding of the latter's role. It seems that most charge nurses are aware of the value of the contribution made by social workers and try to ensure that those patients needing help are referred to them, either through the medical staff or by themselves. Communication between charge nurses and social workers must be good, which involves getting to know each other and thereby developing a sense of trust in each other. The building up of good relations between these two occupations is vital to the patient's wellbeing (Mathews, 1982).

At the BBH there are only two full time employed women in the Department; a qualified social worker assisted by a welfare worker, which is nowhere near sufficient enough for them to cope with the various social problems that emerge. It seems that the administration at the Hospital views their employment mainly as a kind of tokenism.

When asked to explain her job situation, the social worker aired her feelings in this way:

> "Basically we provide general social work services to inpatients who have problems that need immediate attention. With the outpatients our job consists of ongoing follow ups and counselling. We also get involved in housing matters, pensions, grief counselling for dying patients and their families. Often we act as interpretors for the doctors because they can't put things to the patient in lay terms. Patients are sometimes frightened of doctors and come to me to ask advice and to explain in a simple way what is wrong. Even the nursing staff don't have the time or use jargon themselves. We take care of a lot of patients like that. Usually it's those from lower socio-economic backgrounds where there are many social problems such as child abuse or neglect or very young single mums from

the Second Floor at the Stanistreet Building. Drug abuse is another major problem."

On the question of how important other divisions in the Hospital perceive their role, the social worker replied:

"Unfortunately, we are classified as very low priority in this place because we don't generate any finance. It's a numbers game because it's all about statistics as to how many patients you deal with, but they have no idea of the emotional strain and the time that is involved. My figures are down and yet there is an enormous work overload. The atmosphere in the Hospital is changing. It's not a happy place because of all the tension and lack of cooperation. We not only have to counsel patients but more and more staff members come to us for help. Girls I've known for years are in such a state of anxiety and stress! The CEO and his little finance man freak out everytime I approach the subject of additional staff. The Little One had the audacity to come in one day and tell us that he could do with an extra person at his end to do the work of a project officer and if I could spare my partner. They and other areas don't recognize the experise and knowledge that we have. That's how much they think of you. It's incredible, they are so tight you'd think it was their own purse. Typical bloody accountants."

The welfare worker was in complete agreement with her colleague:

"The administration don't regard us as very important. In fact, our meagre funds come out of office funding. We are not seen as medically oriented in any way because they think that we don't really do much except smile at people and give them a bit of an understanding look and hug. My biggest frustration is that there are only two of us in the area and once people leave the Hospital

we can't follow up as often as we'd like to unless something really serious happens or they drop in to see us."

Their relation with the medical staff is again, as with pharmacy and physiotherapy, a power game. According to the social worker:

"We don't really see any patient unless it's agreed upon by the doctor. Some will only be seen by us unless we have written approval. Many of them don't have any time for paramedics, let alone us. They feel threatened that we are going to interfere with their total care plan and regard us as sticky beaks who have no place at the bedside."

In discussing the importance of the paramedical staff in general at the Hospital, a visiting medical officer remarked:

"The influence of the paramedics in this Hospital should be kept at a minimum, especially those fuzzy occupations like social work, speech therapy and so on. It's just inefficient use of labour. They are far too autonomous in my view, guarding their so called expertise and always wanting to be consulted. It's bad enough with the super egos of the twenty-six of us. They should really be under the CEO or Finance because they are non-patient oriented. In fact people like social workers belong outside in the community and not here in the Hospital. We, the medical staff should handle the social and so called psychological problems. That's my job."

From all that I have so far written, it is obvious that the paramedical staff are not in very powerful positions and are therefore lacking in autonomy and prestige. Their work is truly organized around the treatment of the patients and they are ultimately controlled by the power brokers, the medical staff.

As a Medical Imaging Technologist so aptly put it: "The Hospital is the last feudal system where they (the VMS) are the kings and we are the serfs. The power is in their hands because they can dictate to us what is to be done. As soon as we step near the throne we are immediately pushed below where they think we should belong."

GENERAL SERVICES

General service personnel at the BBH provide the basic conditions within which the treatment and care of patients is undertaken. They differ from medical, nursing and paramedical staff in that they are not directly concerned with the diagnosis or treatment for individual patients. Because of this difference, general service departments may lack the glamour of the other services but nonetheless they form the foundation in which these services can be based. The general service component in the Hospital can be viewed in terms of various main functional categories, namely engineering (maintenance), food services, domestic services, and administrative services. These hotel-type and other general supporting departments are all basically hierarchical with a department head at the helm, responsible to the Deputy Chief Executive Officer.

Engineering services

The various Hospital buildings and contained services and equipment comprise a complex system which must continuously function safely and efficiently before one can hope to provide high quality patient care. This major task requires a large amount of maintenance, the development of new projects, the changing of wards, or the upgrading of major equipment. The capital costs at the Hospital are indeed high and it is therefore an economic necessity to ensure that the services and equipment are efficiently operated and maintained. Any unexpected interruption of these essentials could endanger a patient's life.

In most cases the Engineering Department operates on the basis of maintenance by crisis. That is, for most of its fabric and equipment, maintenance only takes place when something goes wrong although certain items such as lifts, toilets and Operating Theatre Suite equipment are maintained at regular intervals and according to certain established standards. The problem is that

a comprehensive system of planned preventive maintenance requires time and more staff which results in increased staffing costs. According to Grant (1985), it is a fault of hospital costing systems that they are not able to readily identify cost elements due to poor maintenance. Although, in the short run, maintenance by crisis appears a cheaper system it is certainly the more expensive method in the long run.

The Engineering Department is controlled by an appropriately qualified and experienced Chief Engineer, followed by an Assistant Engineer and various foremen in charge of tradesmen, such as plumbers, fitters, carpenters, painters and electricians. In addition there are also gardeners, general orderly staff, and oddly enough, a mortuary attendant. There is also a House and Works Committee as a subcommittee of the Board which plays some part in the organization and management of the Department.

When asking the Chief Engineer was asked to talk about his job he sat back and explained:

> "Overall, I'm fairly satisfied because I like what I'm doing and I'm my own boss but it's often a very frustrating business. I feel I don't get adequate management support nor do I have the resources to do what I'd like to do and what is normal and expected in my role. Administrators have no vision and lack the conceptual skills to see where we should be heading. They only see things on a day to day cost basis and wouldn't dream of changing the accounting procedures. And so we get bogged down with bullshit as well as continuous interference by the Government. We are so understaffed and deficient in many ways. Take the purchasing system as an example. There are four different locations operated by four different people according to the type of items requested. It's absolutely crazy; no other hospital, even twice its size operates like we do. The trouble is nobody questions

anything. Not once in eighteen years has anyone asked me as to how I'm going or what are things like. I know they appreciate what I do but there is no interest or assessment. You write reports and point out problems but nothing ever happens. Even the meetings are a waste of time because you're only fed the information that they're prepared to give you. People here are only concerned with their own area and although they may be aware of others they are not particularly interested.

When questioned about his authority in the Hospital, the he said:

"I really think that I'd like to have more of a say on matters, more authority. I feel my job justifies an equal footing with the other executives but they don't want that. They don't want me to go the full hog and so I'm always held back. It's therefore not my right to offer advice or to question anything. However, the cooperation overall isn't too bad and we're pretty honest with each other and a reasonably happy lot."

On the question of whether he had anything to do with the medical staff and whether he thought they were powerful he replied:

"I have nothing to do with the VMO's because we don't talk to them or meet them on the whole. I don't even know how many we've got or what they look like half of the time. They don't really exist as far as I'm concerned. I do know a few of the senior surgeons but only because they come to you when they want some equipment. One wanted some shelves for the Operating Theatre but the Supervisor refused to allow this because none of the other surgeons were interested. As to whether they're powerful I can't really say. I would suggest that the CEO and the MS are the most powerful in that position but they don't utilize that power

effectively because they're too unsure of themselves. The MS because of his race and the CEO because of his inexperience. The CEO is a nice fellow but is always harping on budgetary constraints as well as having big brother (the Health Commission) look over his shoulder. Mind you if the cleaners and especially the orderlies went on strike this place would immediately shut down."

Food services

A hospital is in many ways like a large hotel except that the patrons are not exactly on holiday but are sick. A correct and balanced diet makes an important contribution to the patient's response to medical treatment. In addition, resident staff and some non-resident staff must also be catered for. Hence the food service plays an important role in the Hospital's function and also contributes towards it's image and prestige. The goal of the Food Service Department is the planning, production and serving of good food, economically and efficiently; the liaison with the dietitian in the preparation of special diets; and the purchasing of fresh food (dry foods are purchased through the bulk store). The two functions of providing normal diets for most patients and the staff and special diets as part of the therapeutic regulations for other patients, often leads to confusion in the operation and management of the Food Service Department in the Hospital.

The Food Services Manager is involved in the planning of menus of an adequate standard within the budget allocation as well as the management and training of kitchen personnel. He is also responsible for the purchase, reception, storage, and distribution and serving of the various meals. Next in line, is the Deputy Food Services Manager, responsible for four supervisors in the kitchen, dietary, serveries, and cafeteria areas, each comprising several lower grade staff, namely cooks, food service assistants and apprentices. There is quite an age

and personality difference between the manager and his deputy which is rather frustrating for the latter who is very keen, energetic, and ambitious.

The relation with the dietitian, (there is only one) is creating a great deal of conflict not only because of her personality and inefficiency but because she is responsible to the Medical Superintendent and has an advisory function with the Food Services Manager. If such a liaison is to work smoothly without any major problems there needs to be a high degree of coordination and cooperation between the two parties and their superiors. Each person should be aware of their individual and joint responsibilities in order to avoid misunderstandings.

Again, as in so many previous interviews the same problems and frustrations become evident. They permeate throughout the whole Hospital. According to the Deputy Food Services Manager:

> "You know me quite well and you know how enthusiastic and keen I get when I think of new ideas that I'd like to implement. But my boss is a product of his age and lacks the sparkle and innovativeness. I have to negotiate every step of the way in order to get some change implemented. Although he's good to me there is no leadership or flexibility. It takes me months and months to implement new ideas. There just isn't the interest and even the CEO is too busy with his financial problems. Besides, he doesn't want to rock the boat because my boss is retiring soon. You have to push and push to get things done around here. I just don't bother to go to anyone now. It gets a bit tiring though when you're keen and do all the work, and others get the pomp and the recognition and you yourself are never praised."

Regarding the difficulties with the Dietitian, the Deputy Food Services Manager became quite angry:

> "This particular person should have been sacked ages ago by the Medical Superintendent but as usual nothing is ever solved if there is a problem. She is lazy, sloppy, is not prepared to visit patients, and doesn't offer any guidance whatsoever to my staff. I just don't bother with her any more. Besides, she keeps horses you know, and bloody well smells like one too; a dietitian mind you. It's absolutely disgusting. On top of it, she is in charge of the diet kitchen using my staff but doesn't give any instructions on the various requested diets let alone follow them up. In reality we should have good working relations like a perfect marriage with guidance, advice and help going both ways. But for anything like that to happen around here, you've got to be kidding."

Domestic services

Anyone entering the BBH will notice that the place looks clean and respectable. The functions of the Domestic Services are to maintain clean, safe, and healthy surroundings for both the patients and the staff. It provides the correct setting in which high standards of patient care may take place. This is very important to the orderly running of the Hospital and has a direct effect on the well-being and the morale of the people within it. The Domestic Services are involved in keeping the premises, equipment, and facilities clean and so these functions have to take place in all areas of the Hospital. This means that they have to be coordinated with all the other functions of the Hospital. The criteria of the degree of cleanliness in each area will depend on the standards decided on, the amount of traffic, and the existing condition. An example, is the Operating Theatre Suite (see Chapter 16) which has quite stringent rules as to the degree of cleanliness required.

Again the Domestic Services, like all the other support departments, is organized on a hierarchical basis, although on a much wider span, with a Domestic Services Supervisor, Assistant Domestic Supervisor, and eighty-five staff comprising female and male cleaners working in two shifts from morning till late afternoon, with a supervisor on duty during the evening. There is a lack of first line supervisors, so that the Domestic Services Supervisor and individual cleaners are in continuous direct contact. Its a very labour intensive area with a high turnover of the younger female staff.

In order to try and minimize the turnover rate of the staff as well as perform their work more efficiently, it is important that adequate training be provided and more supervisory staff employed. Most of the cleaning staff feel quite alienated from their work and have no particular attachment to the Hospital. A specific induction programme emphasizing the functioning of the Hospital and the important contribution by the domestic staff may help in reducing the turnover rate.

The Domestic Services Supervisor seems to be quite satisfied in her job and sees herself as an administrator as well as "mother confessor". There doesn't seem to be very much friction between her staff and the nursing personnel. Asked about that relation between the two camps she commented:

> "We don't really have that many problems with staff overall. I do get frustrated at times though, because some of the girls don't pull their weight and can be pretty slack. Some don't feel part of the place. It's only when they work permanently on a ward that they feel more part of a team. Some of the Sisters resent it if girls are moved from other areas because sometimes I have to juggle staff around. The Charge Nurse is their main contact outside my area. I get on well with most of them and there is no friction between us because they are quite happy for me to be in charge. I know what is

expected. I make it my business to go on a round every day to see what is happening and if there are any problems. Different parts of the Hospital need different degrees of cleanliness so we use different products and methods. I'd like to see some of the equipment replaced on a rotating basis and not wait until it breaks down. There should be a continuous monitoring and updating of equipment like at the Home and Hospital for the Aged. Here we always seem to be doing things on a hotch potch basis which goes back to the olden days."

ADMINISTRATIVE SERVICES

The tasks and importance of the administrative services have already been mentioned in various Chapters, especially the role of the Chief Executive Officer and his Deputy. BBH administrators play a key part in the overall running of the Hospital in view of the complexity of that organization and the amount of coordination which is required. Although there is a drive for professional status (even though there is some uncertainty as to the actual skill involved), the administrative services don't always produce the calibre of personnel desirable for such important tasks.

The organization of the administration tends to be fairly rigidly hierarchical with the Chief Executive Officer, the Deputy Chief Executive Officer, the Administrative Officer General, the Finance Officer, and so on, right down the line to the clerical staff. Apart from the Chief Executive Officer and his deputy the other two key playes in the Division are the Administrative Officer General and the Finance Officer. It is thus important to throw some light on the nature of these two positions.

The Administrative Officer General is responsible for three main tasks, comprising personnel, which includes workers' compensation and superannuation; purchasing of complex items of capital type equipment; and general duties which involve auxiliaries, the bulk store, the telephone system etc. These tasks involve a great deal of conflict due to role overload and ambiguity.

Discussing his multiple of roles and the nature of his task, the Administrative Officer General declared:

> "I realize that my job is quite unique because of the way that the beast has grown up. Combining the functions of personnel, purchasing, and general duties was a stop gap measure due to the lack of conceptual thinking by the administration in earlier days.

conservative management for so many years has paralyzed the total system and its damn hard and takes time to loosen things up. Thus my job is quite a deviation from the standard model. The end result is, of course, that I fly by the seat of my pants most of the time. It's crisis management because there is so much on the go and you can't really give one side of the job your best. I don't know how I've survived with so many irons in the fire. I guess it's a question of juggling, trying not to drop any of the balls. If you can avoid a crisis in the eleventh hour then you've made it. If I had the luxury and could concentrate on only one main job, it would give me enormous satisfaction, but wearing three hats so to speak often causes me great anxiety and strain."

When asked about his contact network, the Administrative Officer General felt that:

"There is good working relation and rapport at the senior administrative level. I work in close liaison with the Deputy CEO and to some extent with the Finance Officer. The boss understands my problems and frustrations because to some extent she's been there and has come up through the administrative area. She is very sympathetic to my problems and often consults me on various decisions that affect me. I also liaise fairly closely with the Finance Officer and the Accounting Department. We are all very much aware of fiscal control. My chart tells me to spend and my financial colleague tries to find the money for me. Overall, we work quite well together. Others outside our department very often don't see the reasons for some of the decisions that have to be made. They don't appreciate the problems and will always put holes into the management decision. People don't look at all the variables and only appreciate their own world or the one

to one relations that they have in the system. To them its just that particular job on that particular day that's important."

Because hospitals in general are becoming more and more finance conscious, including the BBH, the task of the **Finance Manager** is also very important, although this position, and what it involves is to some extent part of the Chief Executive Officer's task. The Finance Officer is responsible for the processing, recording, and preparation of all financial data as required; the supervision of the receipt and banking of all monies; the raising and collection of all patients' fees; the preparation of statistical statements; and the supervision of the payroll.

The staff that report to the Finance Office comprise financial and clerical personnel and receptionists in the Casualty Area. Although the position is under the control of the Deputy Chief Executive Officer, the Finance Officer reports directly to the Chief Executive Officer because of the importance attached to the financial decisions that have to be made regarding the daily operations of the Hospital.

When asked about the importance of his position, the Finance Manager remarked:

"Because of the importance of my job I don't see why I should be accountable to the Deputy Chief Executive Officer. I deal directly with the Chief Executive Officer because he must be aware of what is happening financially. My job is to put Government policy into practice by allocating funds accordingly to the priority and the policies of the Board. The efficiency of this Hospital is measured in dollar terms. Our wages and salaries alone make up about eighty percent of the budget. I control this salary budget and yet have no say over the number of staff and the level at which

they are appointed. It's rather frustrating in not having much say on financial matters. After all, I am the Finance Manager."

PART IV

WARDS, THEATRES AND PATIENTS

In this section of the thesis I shall deal with the main observational studies of the three wards and the operating theatre suite as well as tracing the journey of the three individual patients within the wards.

My choice of presentation is to begin with an outline of the admissions procedure, followed by a discussion of some general features of wards and their management. This will provide a perspective which may help the reader to follow the later discussion.

I shall present each ward in turn, to provide a description of the context in which the patient finds himself or herself ending with by a discussion of the Operating Theatre Suite.

CHAPTER 11
ADMISSIONS

THE PATIENT FLOW PERSPECTIVE

The patient or the "human material" is taken from the environment into the operating core of the organization, is then altered in a predetermined manner through a series of activities performed by a groups of individuals, and finally returned back out into the environment again. In fact, the person as the patient represents an interesting combination of the role of client and work product itself.

The patient flow perspective is an example of long-linked technology (Thompson, 1967) characterized by tasks or operations that are sequentially interdependent. Managing the relations between the subsystems becomes important because effective co-ordination is required. Following the patient through the system, I endeavour to describe the "traveller's" various encounters with things and people and the conflicts that occur. A number of tasks, both professional and non-professional, together with the appropriate technology, will be performed around the patient in the process of looking after the patient.

As I explained in Chapter 2, task systems are systems of activities plus the human and physical resources necessary to perform the activities. We are looking at the various operating systems which are the task systems (e.g. Admissions Office, Orthopaedic Ward, Operating Theatre Suite etc.,) that are concerned with some stage of the dominant input-conversion-ouput process through which the primary task of patient care is performed. Where the action changes or there is a discontinuity in the system, a boundary will have been crossed.

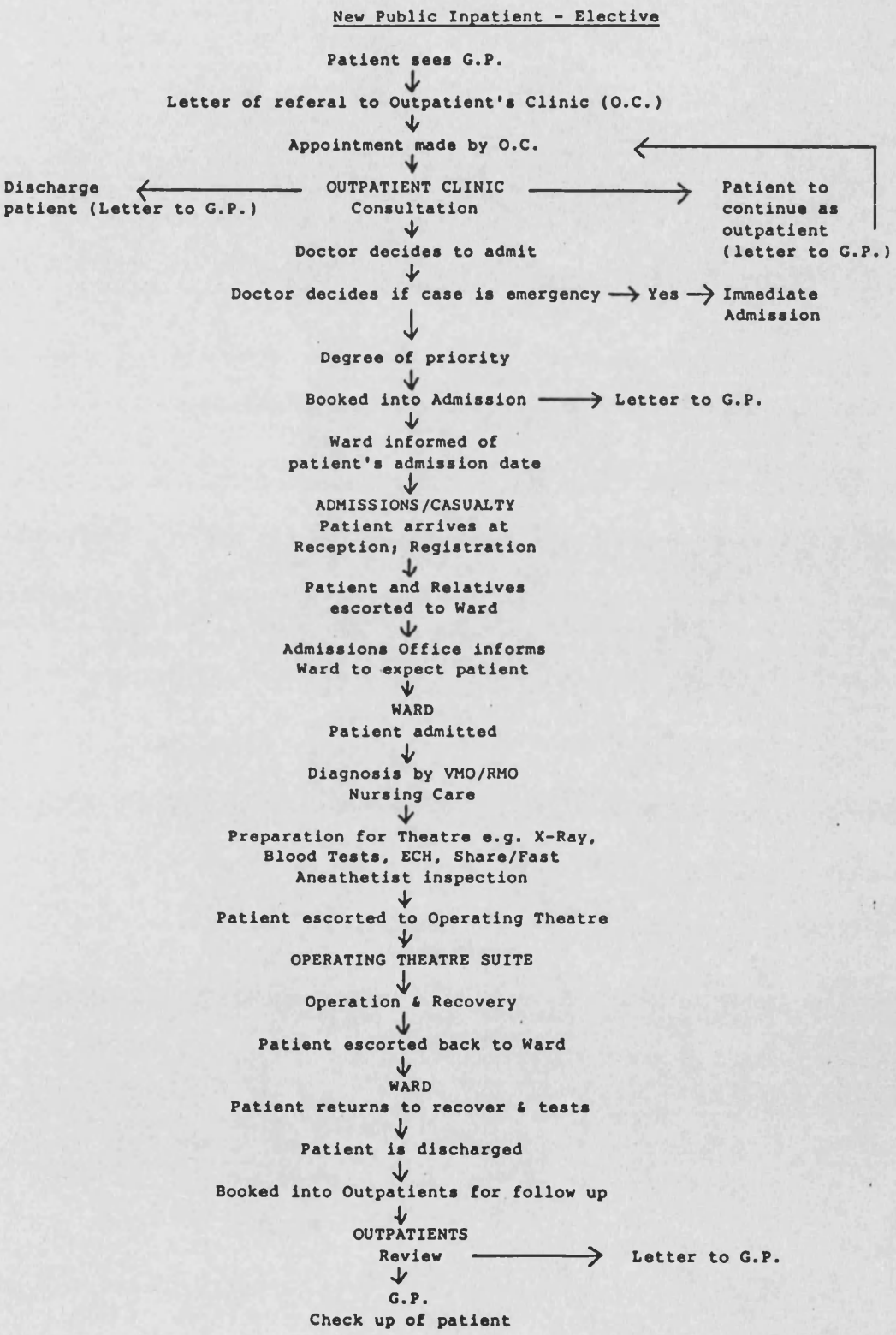
The route to the Hospital can be compared to some extent with Suchman's (1965) model which follows the various stages of symptoms experience, assumption of the sick role and medical care contact, up to the dependent - patient role. At this stage both the patient and the doctor agree that treatment in the Hospital is necessary and thus arrangements are made to have the patient admitted. Once admitted, the socialization process of becoming a patient and entering the "patient role" begins.

This route or patient flow through the system, together with the socialization process, can also be analyzed by what Glaser and Strauss (1971) call the phenomenon of status passages. The idea has been developed from Arnold van Gennep's "Les rites de passage", translated into English in 1965. Status passages can occur within occupations (e.g. careers and socialization) and within organizations (e.g. mobility). As Glaser and Strauss (1971:2) point out:

> "Such passages may entail movement into a different part of a social system; or a loss (or gain) of privilege, influence, or power, and a changed identity and sense of self, as well as changed behaviour."

Because a status passage is constantly in motion, a major concern of the passanger (the patient) and the agents (medical care personnel) involved in it, is whether the passage is either reversible or non-reversible. As I indicated in Coe's model of patient care, the assumptions about the patient's disease is that it is reversible. Reverses in the passage are preventable and it is up to the patient and the medical staff to ensure that no changes occur in the direction of the passage. Doctor and patient usually cooperate during recovery passages to ward off reversals in the illness. Figure 8 describes the patient flow of an inpatient from the outside world or community through the Hospital admission area into the nursing wards and treatment areas and discharged back into the community.

Figure 8. Admissions to discharge.



THE ADMISSIONS OFFICE

The admission procedures used by the BBH organize the patient into the system, and orient the sick person to the traditional patient role. That is, once the patient has passed through the doors of the Hospital, thereby crossing the boundary from one culture into another, and becomes involved in the admission procedure, he begins to feel like a traveller in a foreign land. The impact of hospitalization can be a very traumatic and terrifying experience for new patients which requires a sensitive and understanding approach by staff involved in the process.

As I indicated in Chapter 2, it is useful to think of organizational structure as the linkage or network between the organization's environment and the internal task systems. The Admissions Office which is located in the Casualty Department is a focal point of the BBH. Its primary task is to play a part in the regulation of the flow of patients through the Hospital. The Admissions Officer does not direct the regulation procedure, because most of the critical decisions are taken by medical staff. These decision may produce conflicting demands on the Admissions Officer who in thus faced with an additional task of regulating and mediating these conflicts.

The basic functions of the Admissions Office are to arrange, record and facilitate the admission, transfer between different task units, and finally the discharge of the inpatient from the Hospital. Coupled with this is the generation of appropriate medical record and accounting procedures.

People in the Admissions Office perform boundary-scanning roles which link the Hospital and the community across the boundary of the institutions. Individuals who perform these functions have to be able to respnd to various expectations both from outside and within the Hospital which can often lead to a great deal of conflict and stress.

A great deal of their effectiveness thus depends on the personal attributes, dispositions and skills of the staff as well as on the links with other departments and individuals in the Hospital and their cooperation. Therefore, it is important for the well being of the patient that the service is efficient and yet compassionate in its work at the same time.

Types of admissions

There are three types of admissions commonly in use in the BBH covering both public and private patients, each with its own procedures and protocols. The first is the emergency admission, which occurs because of an accident or sudden onset of an illness such as a heart attack or appendicitis. In these cases, the patient usually arrives by ambulance at the Hospital's Casualty Department where an examination is held to discover the nature and severity of the illness. Depending on the outcome, the patient is either sent home again or admitted to one of the wards or perhaps immediately into the operating theatre.

The second type of admission refers to an illness of sufficient severity to require immediate treatment, but not of emergency nature. Such patients are usually referrals from a general practitioner who rings the Casualty Department so that proper diagnosis and treatment can take place. The patient arrives either in an ambulance or by private or public transportation depending on the severity of the problem.

The third type of admission are the planned, non-urgent, elective cases which have been pre-arranged and booked. They consist of patients whose conditions have a sufficiently long and predictable course so that a time has been set for admission at the convenience of the doctor and patient. Such things as elective surgery, periodic physical examinations and normal pregnancies, fall into this category. The latter case, however, is not dealt with by the Admissions Office but becomes the responsibility of Stanistreet House.

Organization

At the BBH, the Admissions Officer is responsible to the Medical Superintendent because of the relation with medical services but has also a close link with the nursing and administrative divisions of the Hospital. The biggest problem is to find a proper balance between the different type of admissions due to limited resources and the different expectations of the medical and nursing staff involved. It is a typical case of inter-sender role conflict where the Admissions Officer finds it difficult, if not impossible, to meet the various expectations from the different parties concerned. Stanistreet House which is the maternity wing of the Hospital, does not come under the control of the Admissions Office but handles it's own admissions. The only involvement by the office is the booking of the operating theatre for caesarian operations.

Discussing her job and the inter-sender role conflict that she faces, the Admissions Officer explained:

> "Because my job is basically medical oriented I am responsible to the MS. I spend most of the time on the phone and find my task often quite demanding and exhausting. For a start the job is very diverse and there are so many discrepancies. Nothing is cut and dry. Not only do I have to handle so many people with so many different ideas but all my decisions affect

someone else, such as ward staff, theatre staff, the medical staff and areas such as the Clinics, Casualty, X-ray and so on. One phone call alone can have a chain reaction influencing a whole range of people. I try to compromise and give others a say. It all becomes a question of knowing the system, and the priorities as well as using gut feeling, a lot of common sense, and your own initiative. You learn all that by experience and not out of a book like some people think you can do."

One of the major frustrations facing the Admissions Officer is the relation with nursing administration:

"I don't have any trouble with the medical staff who accept my allocation but it's nursing administration that continuously hassles me in trying to justify my allocations. These people wouldn't have a clue as to the urgency or sickness of a patient because they haven't got the experience to understand the basis on which I make my decision as to where a patient is to be allocated and yet they want to take over my job. Take for example, an emergency case which we never refuse but it means cancelling an elective, or sending someone home, or juggling the ward occupancy and making staff changes. I have quite a good relationship with the charge nurses who now control ward allocation on the basis of their staff availability. However, none of the nursing administrators nor the DON are going to tell me what to do."

The nature of the Admission Officer's task makes it important for her to work in liason with the Medical Superintendent, nursing administration, the medical staff and key personnel from the support services. There is also a document available setting our clearly the defined admission and discharge policies.

There is no doubt that the administration of admission of patients to the BBH can be a complex and difficult problem. Maintenance of a correct balance between elective and emergency admissions, the need for flexibility in bed allocation between specialties, and a number of other problems, can all have an effect upon the standard of patient care provided by the Hospital. It is important to give careful attention in selecting people for these important gatekeeping positions so that needless conflicts and confrontations can be avoided and the individuals themselves are able to obtain greater job satifaction at the same time.

THE GATEWAY TO THE WARD

In all types of admissions, the patient arrives at the office by some means of transportation. From the point of view of the patient, the requirements here are for privacy, a fairly quick throughput, and, above all, sympathetic understanding and a personal warmth of welcome. In most cases, except in an emergency, there is an initial delay which can become very frustrating and anxiety prone the longer the patient has to wait.

The admission interview can be a disturbing moment for the patient who is confronted by a clerk who usually asks in a matter-of-fact manner for information about the patient and his affairs. Collecting this information often takes precedence over the patient's needs and anxieties. (It happened to me a few years ago when suffering from an asthma attack, I staggered into Casulty, and was confronted by the clerk who tried to hold me back by asking all sorts of formal questions, completely oblivious to my plight. I simply left and found a nurse who quickly placed a ventilan mask on my face).

Once the admission information has been obtained, a porter is called who then takes the sick person's belongings and wheels the patient (irrespective of whether he or she can walk or not), generally accompained by an adult relative or friend, to the ward. In emergency cases, the patient is taken from the ambulance and rushed to the appropriate destination on a trolley, accompained by a nurse.

Having arrived in the assigned ward, the patient is taken to a particular room where he or she is undressed, personal property is stored, and the bed is ready for accupation. The sick person is now a hospital patient with a room and a bed number, whose welfare is going to be in the hands of the people who inhabit this new and strange world.

The admission procedures organize the patient into the system, and orient the sick person to the traditional patient role. It is a new social situation that involves additional influences on the patient's behaviour and on his or her illness and treatment. It is made quite clear to the patients entering the entering the Hospital that it has accepted them on its own terms and that its rules and regulations have to be obeyed and its culture accepted.

CHAPTER 12
WARDS AND THEIR MANAGEMENT

The heart of a hospital is the patient ward or nursing unit which forms the basic module for inpatient care. It is the nursing unit where the core of the hospital's activities take place: patients are received, diagnosed, cared for, treated, and discharged. Most of the other inpatient facilities of the institution exist to support the needs of patients and health care personnel on the ward.

The nursing units of the BBH are grouped primarily along territorial differentation ("second floor", "Hyett Block", or "Stanistreet House", etc.) and technological differentiation or medical specialization and client (ie. the second floor of the Hyett Block houses Ward 1 - the public male surgical patients and Ward 7 - the childrens). Each of these nursing units or subsystems forms its own unique subculture within the total system of the hospital. Floors and wards thus vary as to the type of illness, patients, and procedures. That is, they are little communities in themselves reflecting differences in medical technology and tasks, the types of patients and their psychological needs, the relations among the various occupational groups, and the nature of supervision being implemented. (Burling et al. 1956).

Two systems of functions

We find two systems of functions that operate interdependently and yet separately within the total complex of patient care. The "cure" function involves direct therapeutic practices and the process of diagnosis and treatment. The "care" function, on the other hand, combines various functions which are part of the overall task, namely bed and board; services which are subsidiary

and supplementary to the cure process such as those provided by the paramedical staff; and overlapping both of these, is the ministering function carried out by the nursing staff which concerns the commitment to meet the physical, emotional, and physiological needs of the patient.

Nurses provide the continuous care, and are also involved in the cure process carying out activities delegated to them by the medical staff. They are organized as a bureaucracy and each employee is an agent of the institution which employs him or her. It is the the medical staff who are primarily responsible for the cure function. They also see themselves as managing the caring of the patients. The visiting medical staff as free agents, each individually responsible for his or her actions, and their relations with each other are collegiate. They take a supervisory role with junior resident staff.

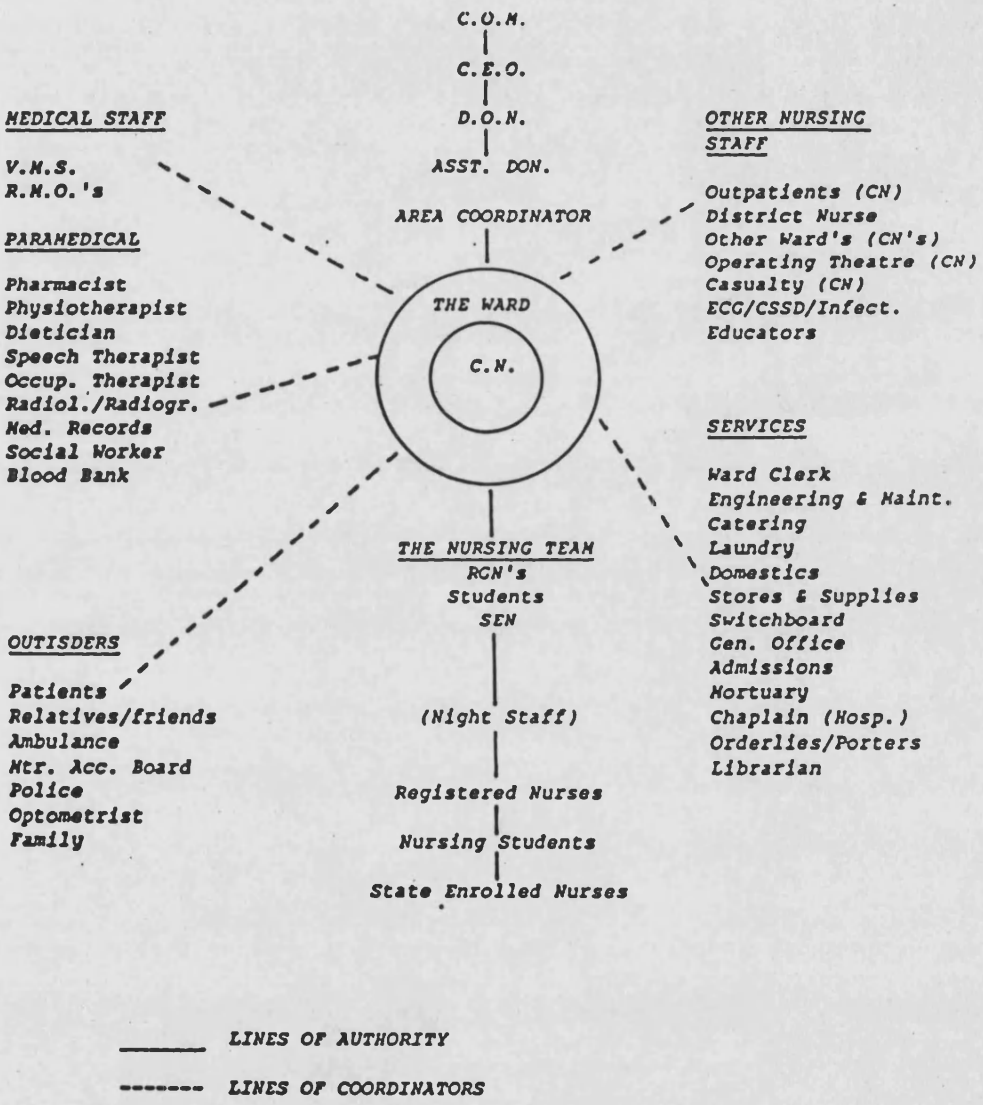
The administrative demands of the cure process are the responsibility of the hospital which translates the individual act of therapy into an institutional process which provides the mechanism or the means by which the doctors and the patients are able to come together. It is at the level of the ward and the operating theatre that the cure process joins with the processes of care.

Organization

The wards and their management are affected by the structure of the Hospital and many forces and influences around it. The ward is where many of these influences are focused and it is here that one can see the practical consequences of managerial decisions made at the Divisional and Executive levels.

A look at Figure 9 makes it obvious that in terms of the distribution of responsibilities, the ward can be seen as the front line of the institution. The lines of organization focus

Figure 9. The Charge Nurse's contact network.



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on the Charge Nurse (Unit Manager) who is the linchpin in the organization of the ward and who is responsible for all aspects of patient care on the ward. The Charge Nurse is a key player in meeting the patients' needs for treatment and rehabilitation. A variety of services converge, through the coordination of the Charge Nurse, on the patient in the ward.

The Charge Nurse is responsible to the Area Coordinator who in turn reports to the Director of Nursing, thereby connecting the unit with the Nursing Division. The Director of Nursing appears as the extended arm of the Chief Executive Officer. The Charge Nurse therefore not only conveys the mandate of nursing administration, but also that of the administration of the Hospital.

Looking at Figure 9 one can see that very few individuals in the top three echelons function on the ward, or even appear there except under special circumstances. These are the people who carry the overall responsibility for patient care. Of the individuals in the lower three levels only the Charge Nurse and her staff are continuously present on the ward. They are bound by time, place, and by the social systems to maintain continuity in patient care. Others who have additional responsbility elsewhere in the Hospital system come and go on the nursing unit at their own convenience or when it is necessary. As a result, the Charge Nurse has, of necessity, been given the task of coordinator of patient care and administering her own unit.

THE CHARGE NURSE

The role of the Charge Nurse

The Charge Nurse is conflict prone in that she is the focal person in negotiating the care of patients. Her role is profoundly affected by her obligation to represent continuity of time. The continuity of time creates accountability due to the nature of patient care. She is expected to keep order in the flow of traffic and in the sequence of events that are scheduled for the patient.

Because the Hospital and the wards within it are open systems, they are interrelated and react upon each other allowing people to come and go. It is the duty of the Charge Nurse to be physically present in this hustle and bustle and coordinate those many transient specialists. Moreover, being in charge of the ward, the Charge Nurse also takes on the "figurehead" role to whom everyone turns as I have shown in Figure 9. A study by Pembrey (1980) suggested that a ward sister is interrupted on average, every six minutes, which gives some idea of the constant demands made on the incumbent.

Atmosphere

I have already mentioned that patients have their own problems to cope with as they attempt to adjust to their new acquired role demanded of them. It is important to realize that they enter a situation which is already fraught with tension causing also problems and anxiety for the staff in this particular social system.

There is no doubt that the Charge Nurse plays an important part in determining the atmosphere of this social system called the ward. The atmosphere may be defined as the state of relations between staff and patients. Mathews (1982) suggests that the

whole ward centres on the attitude and example portrayed by the Charge Nurse and that she is often the one stable element within the ward to control and maintain the right atmosphere. The latter, in turn, will affect the staff's attitudes to their patients, their colleagues, and their work. There are many things that affect that atmosphere and create tension in the ward, such as staff shortages, the mix of staff required, personal incompatibility and non-cooperation among staff as well as the pressure of work generally (Congalton and Najman, 1971). The way the Charge Nurse perceives and plays her role is thus vitally important. Her approach and attitude towards others will influence her behaviour towards nurses and patients alike and thus affect the whole atmosphere of the ward.

Manager and clinician

Changes in the nurse management structure have influenced the Charge Nurse's role consisting of the following tasks: responsibility for administration of the ward and for coordination of patient care services; adminstration of nursing; cooordination of patient care activities; and the supervision of personnel. The Charge Nurse is the only person who has direct managerial responsibilities for both patients and nurses. This creates a source of potential conflict between the incumbent's dual responsibility for the management of patient care and the ward.

Thus the major portion of her time is required to keep the ward continuously functioning whilst administering and coordinating patient care. Between the administrative task and the coordinating function, the Charge Nurse has very little time for her clinical and teaching functions. There is often a conflict between the clinical, managerial and teaching functions of the role and many Charge Nurses want to have more contact with patients.

The Charge Nurse as Coordinator

In considering the ward as an operating system we can see that there is a task boundary around the patient which does not coincide with the ward management, that is, the Charge Nurse's management boundary. There are those activities carried out by the medical, paramedical, and support staff over which the Charge Nurse has really no control. The doctor has autonomy and control over the patient and the other staff are responsible to their own supervisors. This absence of direct control has created a situation where the Charge Nurse is not only responsible for the administration of her own unit but has also been allocated the task of coordination which often leads to tensions and conflicts.

Mauksch (1966) has delineated three phases of coordination which allow a outline of different managerial tasks and the problems that emerge from them:-

Coordination within the care structure. Within the care system, the Charge Nurse serves as a kind of traffic policeman coordinating the various discrete tasks and movements of the other players from various departments. That is, the services rendered to the patient in the ward converge into the administrative domain of the Charge Nurse, who is expected to assure sequence, timing, implementation, and continuity. The administration of the Hospital and the medical staff hold the Charge Nurse responsible for tasks over which she has no control, as I indicated above.

Mauksch (1966) emphasizes that the power of the Charge Nurse to implement this coordinating function derives from her functional association with the doctor. That is, she acts as the doctor's delegate within the care structure. This process appears to work fairly well at the BBH because the various departments are aware of each other and of the interrelations of their functions. However, there are often situations that result in problems, antagonism, hard feelings and conflicts.

Coordination within the cure structure. The Charge Nurse's role takes on different dimensions in her second coordinating function. Patients at the Hospital share the physical facilities and the nursing resources of the particular ward that they are in. Thus any number of patients will each have their own attending specialist and/or a resident and intern as well, who all come to the ward on behalf of these patients. As I indicated before, the visiting medical staff at the Hospital are not a cohesive group and are often in conflict. Each doctor is his own agent and has really no need to consider his colleague with whom he must share the time and services of the nursing staff. Each visiting doctor demands the best and the most for his patients and each has the right to give their opinion and initiate some directive on the basis of their power and prestige. Thus the managerial task of the Charge Nurse is the coordination of an aggregate of isolated orders and directives. The Charge Nurse also frequently mediates between the visiting staff and the resident medical staff who care for his patients. Not only that, but some time is often spent in certain aspects of medical cure.

Coordination within the cure structure also involves the initiation and integration of the tasks of her own ward team. To the ministering tasks of nursing must now also be added the aggregate of medical orders. If these demands become too great for the ward system to cope, then the Charge Nurse must be able to set certain priorities by translating the needs of each individual patient into a system and hierarchy of activities.

Coordination between the care and the cure structures. The Charge Nurse has the dual position of being the representative of the administration as well as being the deputy of the doctor. It is a point where the cure system converges with the supportive and facilitating system of the Hospital itself. She is employed to give care, but because she carries out the orders of the doctor, her role crosses onto the cure function. There are occasions when these two social constructs conflict and it is up to the Charge

Nurse to mediate between the two systems. She is in a position where she must remind the medical staff to abide by the rules and the policies of the Hospital which are usually formulated by some agreement with the Medical Staff Group, the Executive, and the Board. There are numerous instances at the Hospital where the medical staff do not always comply with certain regulations relating to documentation, patient charts etc.

The difficulty is due to various aspects one of which is the power and the autonomy of the doctor coupled with his free-flowing communication prerogatives through the formal bureaucracy of the Hospital. Any direct conflict between the doctor and the Charge Nurse is subject to unequal privilege within the system. The former must report any clash or problematic incident through proper hierarchical channels; the doctor, on the other hand, is free to go directly to any of the member of the Executive. This, in fact, happens quite frequently in this Hospital. In addition, this problematic situation occurs within a climate which is very sensitive to sex roles. The Hospital is an arena where power relations are also highly sexualized and where one finds a strong patriarchical form of control.

When a doctor's orders or actions conflict with the rules and the policies of the Hospital, the Charge Nurse has to make a decision because of her dual role in the system. The choice will depend upon the nature of the request, the relation between the doctor and the Charge Nurse, and the latter's personality and experience. What it really boils down to, is that this dual role places the Charge Nurse in a position where she must use a great deal of communication skill, diplomacy, tact, and flattery.

CHAPTER 13
THE SURGICAL PATIENT IN WARD 1

THE WARD

The Male Surgical Ward (Ward 1) is a public ward located on the First Floor of the Hyett Building with a twenty-four bed capacity, spread over nine rooms; four containing single beds and the rest housing four. A double corridor arrangement on either side separates the various rooms from a central service core area comprising a store room, pantry, toilets and bathrooms. Thus the ward provides suitable accommodation and an environment where various services can conveniently be provided. The physical layout of this ward (like all other wards) influences the amount and kinds of interaction possible.

The Nurses' Station is located near the lift entrance and faces the two corridors. The Station itself is divided into various subcompartments; one for the Charge Nurse, another for the resident medical staff and the rest for the reception of different Hospital staff. It is mainly here that the Charge Nurse is continuously confronted with contact network ranging from residents, paramedicals, the nursing staff and occasionally people from administration.

When one enters the First Floor one becomes immediately aware of clean polished floors, people hurrying to and fro in different uniforms, patients in their pyjamas going for a walk, the movement of a trolley down the corridor and the frequent ringing of a phone as paging of a person over the intercom.

Much of the daily work in this ward is routine patient care, hotel-like services the medical and technical component. This daily routine, with its regular markers, such as breakfast,

newspapers, bed-making, ward rounds, lunch, rest-time, tea, visitors and bed-time, all tends to structure and influence all other activities in the ward.

The types of patients who are admitted to this ward are surgical, emergency and general cases and vary in age although they are mostly older patients. Some of these patients need surgery for such illnesses as appendix, gall bladder, prostate glands, kidneys, eyes, ears, nose etc., as well as anything that is broken whether legs, arms, ribs or backs. The stay in the ward varies from a few days to several months. The ward operates on a twenty-four hour basis comprising three nursing staff shifts, - Morning, 7.00 a.m. to 3.30 p.m.; Evening, 2.30 p.m. to 11.00 p.m.; and Night, 10.45 p.m. to 7.15 a.m.

WARD MANAGEMENT

Ward 1 is managed by a Charge Nurse who is responsible to the Area Coordinator but primarily to the Director of Nursing. The incumbent must hold an appropriate Certificate as Diploma of a Registered Nurse, and have wide experience in the appropriate area of nursing. This is important as she is the authority for nursing care standards within the ward area. In addition, a qualification in Ward Administration is desirable because of her role in administering the ward as well as coordinating the activities of the various specialists operating in the ward.

The Role of the Charge Nurse

The Charge Nurse of Ward 1 is a woman in her middle forties who has been in charge of that unit for seventeen years. She is regarded by many staff members as a competent manager and coordinator who runs an efficient nursing unit. When asked about her job and what makes this ward unique, she smiled and declared:

> " I love my work because I and my ward are at the centre of what this Hospital is all about and therefore I play a very crucial role in the running of this ward. It's where all the initiative comes from. It's interesting and I meet some very interesting and varied people. I revel in the buzzing of it all and am really at my best when the pressure is on. Knowing that you are doing something worthwhile helps me to work more efficiently. I like this type of ward because there is something different going on with these surgical patients and there is often a lot of trauma and emergencies. You've really got to be on your toes here. Also I like working with surgeons rather than physicians because of the type of patient. The illness is confined to a certain area of the body and so its just a question of whipping in the scalpel and removing the poisoned or damaged part. It means that there is no prolonged agony as in the medical ward and patients get better much quicker. I

also prefer to look after male patients. You can joke with men generally and they are not so neurotic or over-sensitive as many women tend to be."

On the question of the centrality of her position the Charge Nurse commented:

"Being central, I'm the coordinator of many things as everybody comes to me and I've got problem-solving on my hands. Most of the people that I encounter are, of course, patients, the medical staff, nursing people and some paramedical. Whatever occupation you look at they vary as to personality and competence. Most of the job I'd say, involves administration and especially getting on with people. That is, communicating effectively and using diplomacy. If you don't do that people won't come to you with their problems which then build up and you don't achieve your objectives of running an efficient ward. You also learn to change your behaviour depending on who I rotate with. I'm lucky I guess because I can use my social skills. You just need some basic common sense. I also had a very good teacher in the Charge Nurse under whom I trained and she taught me a great deal about human nature and the idiocyncracies of some of the specialists."

As I indicated in Chapter 12, the Charge Nurse is in charge of her own nursing staff but has no direct control over anyone else which creates the problem of the dual influence system. This is reflected in the following comment:

"I have authority over my staff but that's all. I really have no direct authority over anyone else because they are all responsible to other superiors. The only things I've got in, order to acommplish my coordinating function, is indirect influence because of my experience. It all depends on respect I suppose. If you haven't got that, nobody will take any notice of you

even if you have the authority. I think it's a combination of clinical knowledge, management, skill and, as I said, getting on with people. You've either got it or you haven't."

The Nursing Team

According to the classification of the ward and the circumstances there are normally eight Registered General Nurses including two first-year and four part-time; two State Enrolled Nurses and up to fifteen Student Nurses. A friendly, happy atmosphere is particularly noticeable in the ward where the Charge Nurse is a good leader resulting in better patient care and effective communication all round. All those working under her guidance are given the opportunity to use their special aptitudes and skills. Moreover, mutual loyalty and trust should be there so that the ward nursing team is conscious of a unity of purpose (Perry, 1978).

In a survey mentioned by Anderson (1973), nursing staff in the UK thought that a well-run ward depended on a sister who was interested in her ward and was well organized, conscientious, considerate, consistent, and happy. According to the Charge Nurse of Ward 1:

"Overall I think we have a happy atmosphere here and the girls like working in the unit. It's all a matter of understanding each member and delegating the tasks according to the experience and the required nursing mix. What it means is that because you have different levels of staff you must make sure you alot the proper training level to the relevant condition of the patient. Sometimes I get very frustrated because my senior staff also have other responsibilities, so when I give them a very sick patient, they don't always have the time required so that a lower grade nurse takes control of that patient. If becomes a question of balancing out the functions of the ward with the staff you've got."

Because of the shortage of Registered General Nurses in the Hospital, it means that at times lower grade nurses, such as State Enrolled Nurses or Student Nurses, have to carry responsibility before they even have sufficient knowledge and experience to do so with confidence and safety. This may result in patients being subjected to the administration of unskilled staff and the latter becoming anxious and tense because of being overburdened with responsibility.

Teaching

Runciman, in her British study of ward sisters (1983), found that teaching worried all the sisters due to lack of time for teaching, uncertainty and lack of confidence about the teaching process and lack of expert specialist help. Even during the ward report (used during the changeover of shifts), which is consdered a good basis for learning, time was too short to fit the teaching in.

Moreover, there is sometimes friction between the nurse educators and the charge nurses leading to the dual influence problem again (see Chapter 10). The response from the Charge Nurse on this matter was:

> "I get quite frustrated with the teaching role and the people I have to teach whether they are student nurses or post-graduates. They don't stay on the ward long enough to really benefit and when you explain things to them they don't listen or apply it half of the time. They vary a lot in their ability. Unfortunately, many of them don't have much common sense which is a big problem because I can't teach that but it's so important in our profession. Also I don't have enough time to devote to training because of the continuous interruptions on the ward and I don't like ward reports anyway."

Teaching and training are significant aspects of the Charge Nurse's role and it is her attitude to learning which affects the learning environment. As Mathews (1982) argues, it is only by creating an environment which is meaningful and conducive to learning that the learners will be more responsive and better motivated. This book is highly regarded by the nursing administration in BBH, and a copy can be found on all wards.

> With regard to nurse training in colleges she angrily replied: "You've got to be joking, because it's going to be the biggest disaster. How can you leave it all to theory and not much practical experience. One has to come through the system to be able to handle it all. That's really when the crunch comes if an important decision on life and death has to be made. It's always the practical experience that wins through. I bet when they come on this ward they'll try and tell me what to do. I certainly won't put up with any of their theoretical stuff I can tell you."

I tried to point out that that was precisely why I was there.

The Charge Nurse and Nursing Administration

The nursing staff, like the medical staff, are not a cohesive group. There is clearly a conflict between nursing administration and the managers of the nursing units, such as this ward. The conflict arises from a variety of factors: the two newcomers at the Executive level (see Chapter 9) and in the Deputy Director of Nursing position; the appointment of a Projects Officer who was widely felt to lack the personality and communication skills for that role; changes in nursing procedures at ward level; and above all the feeling amongst the senior sisters that nursing administration have no understanding of the functioning of the ward and its pressures. Perhaps, as with medicine, the clinician always looks down on the "non-clinician" or administrator.

In Runciman's study (1983), many ward sisters were clearly dissatisfied with nursing administration's contribution to the ward. They were seen to be unavailable as clinical advisers, communications were poor, mutual expectations unclear, and the relation unsupportive.

At the BBH, some of the Area Coordinators (see Chapter 10) are considered by many charge nurses to be lacking in clinical knowledge and completely out of touch with the culture of the wards and were thus seldom approached for guidance or support. This is especially important to the charge nurses because of their lack of authority over the non-nursing functions performed on the ward, and especially because of the power and the autonomy of the medical staff. In order to perform their role as managers and coordinators, charge nurses need effective support from middle management.

The Charge Nurse of Ward 1:
"It's a pity but we really don't get on very well with the girls downstairs. Most of them sit behind a desk pushing a pen or designing some new form we have to fill in. Never mind the patient who doesn't get seen to because I'm bogged down in bloody paperwork. He's the one who gets neglected because I'm too busy trying to keep up their so called standard which revolves purely around administrative matters. There is only one that I know of that has had actual charge nurse experience. The majority haven't got a bloody clue what goes on here and are completely oblivious to the pressure I'm under. No one ever goes out of their way to solve my problems; I can solve them much better myself anyway. How can I possibly seek their advice and support when they really know less than I do."

DOCTORS, NURSES AND OTHER HEALTH PROFESSIONALS

At the BBH the relations between nurses and the medical staff are still to some extent unilaterial, with most of the power and decision-making vested in the doctor. Conflict is growing, especially between the medical staff and nursing administration to the degree that the relations have been described as becoming critical. The conflicts evolve from within doctors and nurses themselves, from the organizational system of the Hospital, and the influence of tradition.

Both the medical profession and nursing at the Hospital have the same goal, namely the preservation and restoration of the health of the patient, but their work can be visualized lying within two overlapping task boundaries as I indicated in Chapter 12. Neither the "cure" process nor the "care" process is an exclusive domain (Skipper, 1965).

At the BBH, nurses and doctors are developing new practice relations characterized by joint decision making and a greater effort towards a professional team approach. This concept, however, still has a long way to go. The doctor of today can no longer operate on his own but is highly dependent not only on his colleagues but also on other health care workers, especially nurses. Yet many doctors still are not fully aware of the ramifications of this major shift in health care delivery.

According to Bates (1970) the inter-professional relation is characterized by medical authoritarianism and nursing dependence, blocking the realization of the full potentials of the doctor-nurse team. This view has been further developed by Kalisch and Kalisch (1977) who have analyzed various sources of doctor-nurse conflict which lead to a number of roadblocks to effective communication between the two parties effecting the quality of patient care. These sources are listed below and apply to a large extent to the situation at the BBH.

1. Doctor dominance and nurse deference.

According to Kalisch and Kalisch, the doctor's role as healer requires competence and an image of decisiveness, authority, and assertiveness which also means that self confidence is essential. All the doctors I interviewed felt they should be fully responsible for the patient but the thought of openly consulting a nurse seems incongruous. It may well be, that this is a defensive action against anxieties about making mistakes. To recognize a need for others is to acknowledge one's limitations and may therefore be difficult for the doctor. The highest degree of individualism and the desire for independence seems to hamper the doctor's capacity for developing interdependent relations with other health care workes and for being integrated into multi-disciplinary teams.

In addition, many doctors at the Hospital still have the view and insist that they maintain the dominant role in the treatment of the patient. Nurses and the paramedical staff are mainly there to serve him, rather than the whole team working side by side serving the patient. The doctor assumes that these health care workers are merely carrying out delegated functions or tasks which he could perform but can't because of the pressure of time. He doesn't want to know or is perhaps unaware, that he does not have the skill and knowledge which these people possess.

Another source of conflict in this area is that while doctors resent nurses meddling in their territory, they feel that it is their right to meddle in nursing. It stems from the concept that they are the overall authority in all matters of patient care.

Except for a few of the senior nursing staff on the wards, most nurses at the BBH accept the position of deference to the medical staff. Reasons as to why nurses are deferent and thereby contribute to the primarily autocratic relations have already been mentioned earlier. The reasons lie in nursing traditions that have emphasized a role of obedience to orders rather than that of an

autonomous professional; socio-cultural factors such as differences in age, social class, and gender; and the major educational differences between the two parties. (see Chapter 5.)

An interesting comment relating to gender in this context was made by an resident medical officer when she said:

> "This Hospital is so set in its views on male and female roles, its amazing. Apart from the fact that most of the VMO's (visiting medical officers) intend to talk down to nurses they don't even accept us as they do the male RMO's which is more like a colleague. They talk to us and treat us like they do the nurses; in a sort of patronizing manner all the time. You know, even some of the nurses find it difficult to take orders from us. Women don't like taking orders from other women."

Although the result of all this often limits the quality and quantity of communication between nurses and doctors, the charge nurses and other senior sisters at the BBH play, what Stein calls, the "doctor-nurse game" (Mumford, 1983). The nurse is to be responsible for making significant recommendations while at the same time appearing passive. It is done in such a manner that the nurse's contributions seem to be those of the doctor. The doctor, on the other hand, in requesting the advice or assistance of the nurse, must do so in an indirect way.

2. Lack of knowledge of the other profession.

Another source of difficulty causing communication breakdowns is that neither party at the Hospital understands the goals and functions of the other. Both parties place different values on specific parts of the health care process which lead to differences in assessing the relative weight of patient problems.

In the words of an resident medical officer:

"I really don't know what nurses do all day and can only appreciate some of the problems. I don't think that they understand us any better. It's a pity we don't have a mechanism whereby we can get together and learn to appreciate each other's problems and functions. The more senior nurses are willing to talk but the SEN's are scared of us and terrified of the VMO's."

3. Differences in orientation to patient care.

Speaking to doctors at the BBH it became obvious that they focus their interest on physical disease and body symptoms or functions and are usually not concerned with behavioural or personal and social influences in the disease. They are more comfortable and skilled in meeting patients' needs for drugs and for therapeutic or diagnostic technologies than they are in providing a trusting relation.

Nurses at the Hospital, on the other hand, are trained, to produce a more psycho-social orientation. Duff and Hollingshead (1968), however, feel that nurses are becoming more task-oriented rather than patient-oriented and that the nurse's "care" has retreated before the "cure" activities that they have accepted from the doctors.

On the differences in the emphasis on patient care, the Charge Nurse stated:

"People talk about patient care from different perspectives but it all depends on your job and the level of training that you've had. The junior nurses see it as to whether the patient is sleeping, has had a bath or has been to the toilet, whereas the senior staff focus on the patient more as a whole person. Surgeons only come into the ward occasionally during their rounds and look at the patient and see him as an illness

needing a particular treatment and are not interested or aware that patient care revolves around a whole process. The Paramedics are also only interested in what they have to do. The CEO wouldn't have a clue about patient care and if he comes to the ward, I've only seem him once, it's about some equipment puchase or jsut a chit chat. He's really only interested in cost efficiency, staffing, or meals. Very few, if any, from the administration know what I actually do or what happens in a ward. They don't particularly care because it's not their area of interest."

4. Other features of working.

There are various other factors which are leading to the differences between the parties, at the Hospital, namely senior nurses retreating more from direct patient care to administrative duties; the structural nature of the dual authority system; and the lack of professional orientation and commitment.

Regarding the overall relations between the visiting medical officers and the Charge Nurse of Ward 1, the latter reflected and said:

"Most of the medical staff still believe that I'm the surrogate mother or handmaiden, here to follow their orders and jump when they say so, even in my position. They can't understand why nurses need to be educated and I'm sure that they feel threatened by it. Some still think most nurses are there to wipe the patient's brow and shouldn't be involved in non-nursing duties. They have no idea how complicated some of the things are that we have to do. Over the years you learn to sum them each up as to their personalities and what they like or dislike. They all have their idiosyncracies. Some are moody and some fiery personalities and you never know where you stand with them; others again are very

effective medically but lack a bedside manner whereas another one I know is more or less the opposite. You can't really tell them things straight out but have to be very diplomatic about it. You learn to know what you can suggest and what you can't and if I'm on safe ground I quite often suggest things that are then accepted. They have enough respect for you to accept this without getting upset. Some don't like you suggesting things at all but you know it's for the good of the patient because you're there all the time around him. The doctors only come in spasmodically. Anyway, I suggest things in such a subtle way that they think it's their idea. Like I do with my husband."

Discussing the role of the Charge Nurse with some of the visiting medical officers on the ward was very interesting and shed some light onto their perception of that position. According to one of the surgeons:

"From my point of view a Charge Nurse must have two basic qualities and that is, she must be a good administrator who is firmly in charge of her ward and staff and she should also be a good clinician who is able to appraise a patient without getting too emotionally involved. There should be a good rapport with everyone in the ward so that people can get on with their tasks. To achieve all that takes common sense, good communication skills and a solid mentality. I'm pleased to say that the present incumbent measures up very well with all these characteristics."

Another visiting medical officer had the following view:

"The ideal Charge Nurse is one who is intelligent, caring, interested, assertive and sensitive. She should be a good organizer and possess good nursing skills. In fact she is the most important person in this Hospital. A captain of her ship who should really be paid much

more and report directly to the Director of Nursing. Some of these nursing administration people who walk around the ward occasionally with clipboards and their airline uniform are quite useless and do nothing but irritate people who have more important things to do. They could learn a great deal from some of our charge nurses especially the one on this ward."

Interns

Most interns do not usually see themselves as employees of the BBH which means being on salary and responsible to the MS. As Coser (1962) points out in his American study, the intern feels that, in relation to the patient, he is a "doctor", and in relation to the Hospital, he is a student who is on his way to becoming a true professional.

The Charge Nurse and her staff, and all others working on the ward are subject to the authority of all the medical staff in the treatment of patients, whatever the doctor's rank, and including the interns.

The actual authority relations between the intern and the Charge Nurse are fairly complex because they both depend on each other and need each other's co-operation. It is an ambiguous and paradoxical status relation. He (or she) is trained to treat patients, to be competent, to give the orders and thus to enjoy a higher status and prestige. She (or he), on the other hand, is usually older, expects respect because of her experience over the years, and knows the ropes in the ward and the Hospital. Moreover the intern spends only a few weeks on the ward whereas the Charge Nurse represents permanence and continuity on the unit.

Many charge nurses complain that interns are "green behind the ears" in that they lack maturity and competence. The interns, in turn, often get upset because the Charge Nurse fails to recognize his authority.

Many of these sentiments were expressed by the Charge Nurse of Ward 1:

> "The interns we get are a mixed bag. Some are O.K. and want to learn and many are really arrogant. You ask them something and you either get a blank look or a patronizing reply. Many lack basic common sense and above all experience. That's what I'm here for but they think they know it all or don't even try. Some, of course know quite a bit but the majority are very mediocre. Others again are so thick it's incredible and you wonder how they get into medical school. What frustrates me a great deal is that I know what is wrong with that patient and because I'm a nurse and they're a doctor I can't do anything except suggest it in such a way that it's not like an order. I've had situations where the patient is deteriorating in front of your eyes and the intern is quite oblivious to it all and ignores you. In situations like that I go straight to the VMO and whatever he says counts."

One of the interns who has some respect on the ward explained:

> "As an intern you are exposed to a lot of stresses and have to suddenly make an important decision although you are responsible to the Registrar. It depends a great deal on your relationship with the VMO and the Registrar and whether they take the time to explain what they are doing and why during ward rounds. The Charge Nurse is even more important to have a good relation with because you deal with her everyday. You can learn quite a bit from her which makes your practical life so much easier."

The paramedical staff

In the BBH there is evidence of some friction in the relations between nurses and paramedical professionals which is operating against co-operative working. (see Chapter 10). This conflict derives mainly from nurses' perceptions of their having a lower status than that of allied health professionals and from clashes and ambiguities in roles and functions.

Status. Nurses are sensitive to the fact that in their view they are at a lower rung in the pecking order. This is measured, firstly by the fact that the comparative salaries are inequitable and that nurses are still seen by others as the "Cinderella" of the health professions. Secondly, nurses feel that they are not given the degree of respect accorded to them by the paramedical professionals.

Much of the difficulty revolves around the difference of educational preparation for nurses. This is now changing as nurses are being educated in tertiary institutions and will therefore be on a par with paramedical staff regarding their qualifications.

Role ambiguities and conflicts. Another area of contention is that paramedical staff are encroaching on some areas already performed by the nursing staff. This is creating a great deal of uncertainty for nurses who feel threatened, in that any transfer of traditionally nursing functions to the paramedical staff could significantly damage their ministral function relating to patient care.

Regarding her relations with the paramedical staff, the Charge Nurse said:

> "I suppose our paramedics are better than average and I don't really have outright conflict although I get very frustrated at times. Take the physiotherapists for example. They get paid more than I do and yet they come

to me and ask me to tell them what to do and they do it. I'm the one who directs them and tells them who to see although it should be done through the doctors. I tell the doctor that the patient needs a physio and he then writes out the card to give the order. It all goes through us. Anyway they come and go and are only concerned with one small aspect of the patient. We are here twenty-four hours of the day looking after the whole person and taking all the responsibility. So who do you think should have the higher status. Their union is behind them and gives them more money. I just think it's very unfair."

Conflicting frames of reference

All people working in Ward 1 share a common task boundary as they are contributing to a common task. They do not, however, form a single task group. There is an interface between each party or system which has to be managed. Because there are specialists coming into the ward, there are boundaries or discontinuities in group membership and in activities which create conflicts. How these conflicts are managed depends on the authority and power of the Charge Nurse.

From my discussions and interviews it became clear that the surgeons, the residents, the physiotherapists, the Charge Nurse and the Nurse Administrator on this particular ward all have their own unique frames of reference. Each party perceives itself as holding certain decision-making rights quite separate from one another. Consequently, skirmishes break out to remind people about where the boundary lines of task and decision-making are drawn. That is, each party will try to defend it's own territory from the other.

From all this one can see that there are various forces and pressures which have combined to make the management and coordinating task of the Charge Nurse a rather difficult one. The ward is an arena in which groups with different interests interact. There is a diversity of personnel and specialization. There are multiple tasks, and the strain of dual responsibility of managing both the nursing and the ward as a whole.

THE PATIENT: GEORGE

The experience of being a patient in the BBH reflects the convergence of various complex forces which influence the nature of patient care. These include characteristics of the patient, his illness, the external culture of the society outside the Hopsital, and the internal culture of the Hospital.

I shall take the example of George, a plumber in his late sixties who is not privately insured and who needs surgery on a leg which may have to be amputated because of the spread of a serious infection. He is a rather emotional and sensitive man who comes from a working class background and left school at an early age in order to support the family's meagre income.

When asking for permission from the Charge Nurse to interview some patients in her ward, she made out for me a list of likely patients with a brief description of their illness. One of the people on the list was George, and she thought I might him interesting; so I went to see him the next day. I found him, in a a room which he was sharing with three other patients, sitting up in bed reading the newspaper. He seemed a quiet elderly chap. The Charge Nurse introduced me as someone from the College who was here to do some study on our wards. George was quite surprised that a stranger would have the interest to enquire about him in his condition.

The more we talked the more I got to like him, and he told me in quite some detail about what had happened to him before coming to hospital, and his experience in the admissions office. He also talked about his feelings and anxieties whilst in the ward for the last three days. I also talked to the Admissions Office about what had occured with George during the admissions process. From both account I then reconstructed the events leading up to my meeting George on the ward.

Consultation and admission

Feeling a continuous pain in his leg, George goes to see his local General Practioner who, after examining the patient, gives him a letter of referral to one of the orthopaedic surgeons in the Outpatients Clinic. After waiting anxiously two months for the appointment, the day finally comes when, accompanied by his wife, he arrives at the Clinic. Here again, over an hour is spent in waiting for the consultation. During the initial delay, the couple sit in silence most of the time, not only anxious about the uncertainty that lay ahead, but also rather embarrassed because various other people are also present, waiting to be diagnosed. George is in a state of apprehension and nervous about being examined.

After the consultation, the surgeon decides to admit the patient to Ward 1 as soon as a bed is available, since it seems most likely that the leg would have to be amputated. Being ill, a patient naturally desires information about his illness and also wanted to be informed about his treatment plan. Proper information allows the patient to take a more active part in working toward his own health and cooperating with the medical staff who are trying to help him. Although the surgeon knows that the leg has to come off, he tells George that an operation on the limb is necessary without specifying the possible outcome.

The surgeon explains the situation:
"Very often you have to be guided by what the patient is telling you or wants. If they want the truth and really mean it I tell them because I know that they need this information so that they can organize their lives and be able to do certain things. Others don't want to know because it would ruin their lives irrespective of how short it is, and so I don't tell them the full detail. It all comes down to how well the patient can take it. Often I ask the wife or a relative first as to what may be best."

Two days later, George arrives at the Admissions Office and is rather fortunate in being called to the admission desk after only a few minutes delay, in order to complete the required paperwork. The process of the admission interview is not a pleasant experience for patients, especially those who are over-anxious or in pain.

Having completed the interview a young porter arrives, places George in a wheelchair and escorts him to the first floor. Even though it is painful, George wants to walk (perhaps a hidden fear that it may be for the last time) but his protest is ignored. The learning process has begun to show him that the Hospital is in complete control and dictates terms. Moreover, having just left his wife, the patient feels suddenly very lonely and unsure of where he is going.

Seeking further information about his destination is met with irrelevant conversation about the weather, as porters at the Hospital are cautioned not to give patients information relating to their position. As one porter remarked:

> "We are told that it's not our job to give any information. I always tell them that the staff will explain the situation or change the subject to sport or the weather which gets rather boring."

As soon as George enters the BBH he must be turned into a patient. The Hospital has taken over the control of this patient by organizing and scheduling his journey through the system. The whole admission process has now separated George from his wife and society, taken away his self-identity and is now preparing him for his new role as hospital patient. He is being stripped into a temporary role with his old frame of reference filed away for future use. It has been replaced with a new one in order to provide a meaningful context for the desired new behaviour and new attitudes.

George soon realizes that the Hospital is only accepting him on its own terms and conditions, that it will treat him as an incompetent person and that he must therefore submit himself unquestioningly to the procedures, routines and relations of the ward and to the decisions of the doctor and the staff (Taylor, 1970). George has given up and surrendered one to these specialists the care of his person including his sense of personal integrity and viability. In addition, the status of dependency is imposed on him from the moment of admittance until discharge.

Being admitted to Ward 1, George assumes an organizational position with all the implications for normative compliance and sanctions for the duration of his stay. That is, the incumbent holds the position of patient in the Hospital system groping for appropriate criteria in defining his role with reference to a variety of significant relations. George's attitude and reactions are viewed within the context of a system of roles and as a consequence of his effort to conform to perceived systems of expectations. His doctors and his nurses are among the significant others in the network of role relations in which he becomes involved.

Life on the ward

In the lift, George becomes anxious and fearful of the unknown that awaits him. Also being rather shy and fairly uneducated, he feels uneasy and in awe of the professional staff that he will have to face and relate to. The lift door opens and George is wheeled past the Nurses' Station where he is met by one of the Sisters who then direct a Nurse to take him to one of the rooms housing four beds. Having been put to bed and most of his self-identity taken away from him, the care process begins with routine tests, routine cleaning, feeding and toileting.

Having never been to hospital before, George finds himself cut adrift in a strange new environment and faced with the problem of adjusting to this unfamiliar context. The literature, which I have discussed in Chapter 7, led me to expect that George might well be alienated from his usual lifestyle and his status reduced to a largely impersonal one. His behaviour is being controlled through the mechanisms of stripping, reduced mobility, enforced dependence and lack of communication; all a concerted assault on the patient's conception of self.

George has come into Ward 1 without a supportive group of peers. As a loner and newcomer in the Hospital social system he is virtually on his own in learning the informal rules of the ward and consequently has little recourse but to conform to what the ward staff expect.

When asked about how he saw his role as a patient, George replied:

> "I don't know what you mean by role but I've got quite a bit of pain and discomfort. I'm bloody worried about my leg but I'm sure these people know what they're about. You feel so helpless. I really don't know what's going to happen to me. The trouble is I don't want to complain too much or feel a burden to anyone. They are all so busy, rushed and overworked around here."

According to Taylor (1970), hospital patients fall into two categories: those who would like to play a submissive role and those who would like to choose a co-operative role. Patients at lower socio-economic levels as well as those in critical condition seem to want an omniscient doctor and a submissive patient-role. On the other hand, patients at higher socio-economic levels, and those who are not in a critical way desire a more co-operative role and should in fact be permitted and encouraged to do so if they are capable. These latter type patients are willing to accommodate themselves to the reasonable demands of the specialists and the Hospital. However, they want

The Charge Nurse finds that she just does not have the time to spend with the patients as she would like to. Much of her time is taken up with administrative tasks which she enjoys. The whole matter becomes a question of compromise.

> When asked about the problem of communication she replied: "Most of the patients I've got, especially the older ones are quite ignorant as to their illness. They don't bother to ask or understand what's going on and have no idea about how long they'll be here, what operation will be done and when. They don't ask the right questions nor do they have the faintest idea about the functioning of their body. Many are wary of the medical staff and never question anyting but stick up for the nurses most of the time. The uniform system is also a complete puzzle to them."

The anticipation of surgery

The situation is made clearer to George the next day during the morning ward round when the surgeon comes around accompanied by a resident medical officer and the Charge Nurse. Although the surgeon uses a certain amount of jargon, he explains to George that the leg was deteriorating and that an operation has been scheduled in two days for various reasons. Although George is anxious to learn more about that operation, which quite terrifies him, the surgeon, quickly moves on to the next patient. As I indicated before, doctors are the most important source of information for patients but there are several aspects of their relation which made communication between them difficult. Some of these aspects are the circumstances under which they meet in the ward which emphasize the power and prestige of the doctor, the time factor, and the submissive nature of this particular type of patient.

to understand what is happening to them and to become active participants in the care process. That is, what the patient needs is the motivation and the information necessary to carry out his own role. It's allowing the patient to manage his own affairs at that stage when he is able to take it and use it, as I will explain further in Chapter 15.

George is quite willing to play a more submissive role because of his personality, age, background and the fact that he is under a great deal of stress and anxiety. Moreover, because George is temporarily incapable of managing himself the staff have taken over in managing his patient role. After all, why shouldn't they (thinks George), the doctor has the knowledge and the expertise, and the nurses are there to carry out his orders.

George is eager to adjust to his new environment and position and to find out about the expectations attached to it in order to find his bearings and sense of identity. Consequently, he tries his best to observe and to communicate with the health care personnel on the ward but finds the effort very disheartening which doesn't help his psychological condition in any way. What he is extremely upset about is the difficulty of obtaining a satisfactory explanation of his condition.

The communication of information to patients is often deliberately limited at the Hospital to prevent the work routine of the staff from constantly being interrupted and to prevent scrutiny of their work. It also protects the professional stance of detachment and concern. George finds that many of the questions put to the nursing staff are only answered evasively which doesn't help him in putting his confused thoughts in order. According to George, the Charge Nurse, who is the key person in the communication network, explained certain aspects to him but wasn't really able to spend much time with him because of other important duties at the nurses's station.

As the resident MO later remarked:

"I am quite aware that lack of explanation is often a big problem between a doctor and his patient. I find that those from the working class usually have a different vocabulary altogether and even their understanding of the same word is different. The more educated person asks more intelligent questions which I can answer better. I know that on this ward, for example, some patients talk more to the nurses or even the cleaners than the doctor when it comes to confiding. You wear that white coat and they think that you are too high and mighty or too busy to listen and so they don't try to bother you."

Lack of information is a fairly common complaint in that many patients find it hard to obtain information easily from the staff. It causes feelings of distress and often panic because of the fear of the unknown an the helplessness felt by being unable to glean information from staff who usually seem busy and impersonal.

One of the most stressful events for surgical patients is the surgical operation. It's not only the fear of the unknown as I mentioned above but also the experience of pain post-operatively. George is worried about himself, about being "cut", the fear of losing his leg and what that would do to his appearance and body, and even the thought of dying. There is considerable research evidence that patients awaiting surgery experience negative emotions. George, is quite clearly showing symptoms of anxiety and depression through his distractability, forgetfulness, irritability and restlessness. Having learnt about the seriousness of George's condition and also recognizing these early signs of anxiety the Charge Nurse is now trying her best to prevent and alleviate his anxiety by endeavouring to explain what he may feel and see.

Wilson-Barnett (1979) reviews various studies that suggest that pre-operative preparation including detailed explanations tend to effect a reduction to anxiety. Lowered anxiety levels, in turn, have been shown to be associated with the ability to cope effectively with surgery and a more rapid and staightforward recovery afterwards.

On the night before the operation, George is visited by his anaesthetist who explains about the type of pain, methods of pain relief and how to cope with the after-effects. Talking to the anaesthetist about this matter he replied:

> "You know, my job like anybody elses becomes routine after seeing so many patients. It's thus very difficult to generate empathy with the patients because most of the time there is a limited risk involved. When you see several of them the night before the operation and you have to go home for dinner you haven't got the time to get into a human relations situation. However, if someone has a major operation ahead of him (like George) I try and develop some sort of rapport because it's very beneficial for that patient. I think it helps towards the success of the operation and we often find that the patient can cope much better to cope afterwards."

Dumas et al (1965) point out, that often the surgeon, the anaesthetist and the nurse are telling the patient about aspects of the surgery that are important to themselves as far as the performance of their own role is concerned. The anaesthetist is aware that George is very anxious to know the nature of the operation the reason for the anaesthetic and that others in similar conditions have fared well.

THE END OF THE STORY

I came back to the ward after a few days to see how George was getting on. The Charge Nurse told me what had happened to him in the mean time. Being in constant contact with him, she was the only one who had a clear and full understanding of his condition. This illuminated the critical importance of her role in the ward.

George had been operated on the morning after I last saw him. His leg was amputated a fraction above the knee. He returned to the ward and was said to have felt somewhat pleased that the operation was a success and was already talking about the possibility of making use of an artificial limb. After several days he was discharged and went home to cope as best as he could with the new situation.

Looking at George's experience in Ward 1 serves to highlight to some extent a central dilemma facing the Hospital - technical efficiency versus humane service. The Hospital is thus inducing George into the patient role so that it can more easily address the application of medical technology and the routinization of work on the ward. This can be seen as an instance of what Thompson (1967) discusses as the technical core of the task, which enterprises seek to isolate and protect in the interest of organizational rationality. However, he makes the point that the technical core is 'an incomplete representation of what an organization must do to accomplish desired results'. This is clearly so in the case of the hospital.

Thus there is a conflict between the Hospital's instrumental perspective and efficiency and George's expressive orientation. While the Hospital tries to maintain adequate primacy of instrumental function, George is seeking information for emotional support and psychic gratification.

Another source of conflict is seen in the different cultural perspectives on the part of the professional helper and the lay client. The surgeon is trained in the science of medicine, and thus prefers to deal with George's physical symptoms rather than get involved with the latter's psychological need. Situational sources also come into play in that for George the experience of being hospitalized and in pain is a most significant and distressing event; for the staff he is just one of many patients who pass through the ward. His role is temporary and he is totally ill-prepared for it; for the staff it is all in a normal day's work.

George's experience suggests that good "medical" care is not always good patient care. Because of the situation that George is in and the circumstances surrounding it, he is more than willing to capitulate or accommodate. He has no great desire, like some of the other patients on the ward, to exercise control over some of his activities or to get involved in a dispute over who should have the mastery over his role. All he wants is some clarification as to his condition and to maintain a sense of freedom, knowing that this is in everybody's best interest for the short-term duration that he will be in hospital.

CHAPTER 14
THE CHILD AND THE PARENT IN WARD 7

THE WARD

The Children's Ward is located on the ground floor of the Hyett Block and consists of thirty cots or beds averaging an occupancy rate of fifteen beds daily due to rapid turnovers. The ward will admit children up to the age of sixteen years. Admission is for both public and private patients and range from medical, surgical, emergency, and general nursing and take in the full "range of childhood diseases".

The main objectives of the ward are defined in the Charge Nurse's job description which is available in the ward. They are: to provide skilled nursing care to patients, both emotionally and physicallly through the utilization of various specializations and resources; to assist the parents by encouraging them to participate in their own child's care; and to recognize the individual rights of the child and to offer support and guidance for adjusting to hospitalization and a harmonious return to normal life within the community.

The Layout

The paediatric units within a general hospital are designed to meet the needs of children and their parents. These needs have been identified as the need for psychological support, physical comfort and safety, and medical treatment and care (Hamilton, 1978).

Because children need cheerful, homelike surroundings as well as the opportunity to be near others their age, the ward is designed in such a way that it separates to some extent those patients that are up to four years of age by providing cots in one particular area and various bed arrangements for the older children in another section. The ward is not large enough to provide complete separation but overall the purpose is served. There are also seating arrangements for parents who want to sit near their child as well as a small private room where a parent can stay overnight.

In addition, there are small recreation areas and a larger room where the children of all ages can go and play. They can also watch videos, television, play games or read stories and picture books appropriate to the age of the child. Also, around the younger children's beds are pictures of their favorite comic characters and fancy things and strings dangle from the ceiling. The whole atmosphere is cheerful and comforting.

The provision of safety is a constant concern. The ward is thus fairly open with many glass petitions which enable staff to see their patients from many vantage points. Everything is arranged and covered in such a way that no physical harm can come to the children. In order to be able to provide proper medical treatment and care, the ward is also placed near the various specialized services and amenities. There is also an isolation room within the unit provided for children with communicable disease.

WARD MANAGEMENT

The management of Ward 7 is entrusted to the Charge Nurse who is responsible to the Assistant Director of Nursing/Area Coordinator and ultimately to the Director of Nursing. There is a permanent staff of seven Registered General Nurses (three full-time and four part-time), four Mothercraft Nurses, and one Ward Clerk. In addition, the ward takes up to fifteen Nursing Students (2nd and 3rd year only because of the specialty area) and there are also Auxilary helpers who assist whenever needed.

The Charge Nurse

The Job and the Team. The Charge Nurse of this ward is a middle-aged woman who has had twenty-four years experience as a paediatric nurse of which sixteen years have been spent managing this unit. Discussing the job with her she smiled and said:

> "My job gives me a great deal of satisfaction because I love the age group of the patient. The aim is to treat every child for illness so that it can leave us without any dramatic scars. The atmosphere here is very harmonious and the staff are a great team with whom I have a close relation. Each girl is chosen fairly carefully because of the nature of the patient and feels confident that she has an important place. Communication is good and we have a good rapport with each other. The family is the patient to a greater extent. The best way to handle a team like mine is by communication and diplomacy which is more my style. I love being in control and initiating change which I can do because of the nature of the ward."

She then went on to describe that her role is somewhat different to that of the other charge nurses by explaining:

> "This ward would have the most rapid turnover in the Hospital which means we have to be on the alert all the

time. The changeover of patients can vary from two hours to three days. This constant change puts a great deal of stress on my staff. I have been given more flexibility with regard to procedures such as admission and discharge and we also don't follow ward procedures so exactly as others. We don't have to justify things so much to nursing administration. We take any child whether busy or not and I can introduce change and modify things because children are so vulnerable as patients."

In the interest of the physical well-being of the child, a consideration of his emotional needs must eventually take precedence over rules, schedules and polished floors. Emotional welfare is bound up inextricably with physical welfare.

Relations with Nursing Administration. On the question of her relations with the administration the Charge Nurse of Ward 7 said:

"I relate very well with my Area Coordinator although she is full of theory but is slowly becoming more practically oriented. We both click very well and understand each other's problems so there is a lot of support for me. I get a lot of empathy and can express my feelings more freely. As I said before I don't feel so locked in as the other Charges and always have that little door out, in case I need it, which gives me more scope to do things."

Relations with the medical staff. Her comments regarding the doctors reflected those of other charge nurses although the situation is somewhat different as she explained:

"As you probably know by now, doctors vary as to personality, style and ability. On this ward, paediatricians, surgeons, residents, and G.P.'s sometimes come together. We get to know what they like

and dislike and try to accommodate to a certain extent. Some are under extreme pressure when the child is ill. In fact some panic with children. The anxiety is more prevalent because of the child's vulnerability and so experience is essential. Sometimes there is overtreatment because of the lack of experience but we see the child twenty-four hours a day and can get a better assessment. They see only one instant whereas we handle, touch, and care and thus have a better perspective."

Because the Children's Ward caters for both private as well as public patients, as well as different illnesses which culminate due to a road accident, for example, there are often conflicting views as to the treatment of the patient on behalf of the medical staff. When asked about these problems or conflicts, the Charge Nurse replied:

"Apart from personality clashes between, say the paediatrician or surgeon or the G.P., there are instances like you say of a road accident. You have a real problem on your hand because they are all overanxious, as I said before, but also each specialist feels only responsible for his particular area, be it the stomach, the leg or the eye. There is no overlap and so we feel in limbo because we are in the middle and that can be extremely frustrating and stressful for us. They do listen to you though once they get to know you."

THE PATIENT: BILLY

The Charge Nurse gave me the freedom to move about the ward and talk to the children and their mothers. After spending several days in the ward I became attached to a little boy called Billy with blond hair and blue eyes, who reminded of my own son. I became quite friendly with Billy and his mother who came to visit him at regular intervals. It was through the Charge Nurse and the mother that I learned something about Billy.

Billy is the youngest in a family of three. The child has to be hospitalized because of a severe attack of asthma and will be kept in the ward for four days. There, he will be looked after by the family's paediatrician and cared for by the Mothercraft Nurse. All older children from four years onwards are cared for by Registered General Nurses or Student Nurses. The example taken, will try to show the implications of Billy's illness and how it affects not only himself, but his mother and the health care staff around him. His experience in this hospital is quite different to that of George, the surgical patient. The chief concern of the hospital, and especially the people in Ward 7, will be to provide him with the highest standard of care and try to reduce any emotional stress he may suffer so that he can recover maximum health in minimum time and return home to his family. Moreover, children are special with regard to hospitalization. The experience is not only very traumatic for such a young child because of the illness itself but because it means leaving the care of his mother no matter how kindly the hospital staff care for him. Consequently, child, parent, and hospital form an intricate set of relation which is unique in the hospital setting.

Billy, like any other child, is a whole person which is the combined result of his inherited characteristics and the social sub-system of the home in which he is being reared. The Hospital, on the other hand, constitutes a totally different cultural system. On entering that institution, Billy moves from

the home-centred system to the Hospital system and his behaviour there will be influenced by the type of person he is and the impact upon him of the social system he faces in the Hospital (Stacey et al., 1970).

Reception of mother and child

Because of the urgency to be admitted, Billy, accompanied by his mother, who is extremely concerned and only too eager to come with him, are taken late afternoon to Casualty where he is given an injection and then put on a ventalin mask. The mother, assured that her boy is breathing reasonably well is taken over to admissions to fill in the necessary forms. They are then both taken straight to Ward 7 where Billy is then put straight into bed. The admission procedure into the ward seems to be always efficient and the reception by the staff helpful and considerate. This initial contact is always important and must be handled with efficiency and consideration because a negative first impression can only add to the mother's general concern, uncertainty and harrassment just at the time when the confidence of the child depends on how secure he senses his mother to be (Stacey et al., 1970).

Hospitalization and reaction

Being in hospital for the first time is very traumatic for Billy because the shock of losing his mother, who had to leave eventually, and all the other stresses to which he is subjected to, are too much for his little body and mind to cope with. Waking up the next day he finds himself removed from home, family, and his dog, and placed in an unfamiliar environment with all strange people around him. Although he has his favourite Teddy with him, he is restricted physically to his cot and he can't understand why he is there in the first place. Above all, he feels very lonely, frightened, confused, and grief stricken because his mother is not there.

Robertson (1970) points out, that the psychological needs of children, up to about seven years, are extremely important. When a child, like Billy, is admitted to hospital and separated from his parents, he passes through three stages until he "settles in", depending on the length of the stay. The first, is one of loud protest by crying, refusing to eat, and looking around for any sign of Mum. This is then followed by a stage of despair, because he realized that his mother is not responding to his crying and, being sensitive and very close to this Mother, Billy becomes silent and depressed and quite preoccupied with his sorrow. When his mother returns that evening, (having had other problems at home) Billy is still deeply hurt and denies that she is back. Some children who are in hospital only a short time may only reach the stage of despair or even just the initial phase.

Billy stayed on the ward for four days. His mother came to pick him up, and they both left smiling to goodbyes from the nursing staff.

That is the end of the story of Billy. I shall now discuss features of the life and work of the ward which affect the experience of Billy and patients like him.

THE WARD AND BILLY'S EXPERIENCE

It is important that both parents and hospital staff are aware of the significance of the different phases which Billy is undergoing during his separation from his mother and his home. Some mothers cannot understand these reactions and become quite distressed. It's then up to the nursing staff or the doctor to explain the situation.

When discussing that hospitalization can be a very difficult experience for a child, the Charge Nurse commented:

> "Yes, indeed, hospitalization for some children can be a very traumatic experience. Some suppress it and others express it to such an extent that they throw temper tantrums and become quite violent and disruptive. It varies as to how prepared they are before coming in here and how we handle the situation. You can win over any child providing you go about it the right way by talking, cuddling, comforting. Children feel that you care and that's how you gain their confidence."

The Mothercraft Nurse had very similar views:

> "I think being very caring helps a child overcome his anxiety of the unknown. You have to be patient and communicate in the right way. A secure child is much easier to manage because it's more independent and can handle things once Mum has gone."

Factors that influence Billy's reactions to hospitalization

According to Klinzing and Klinzing (1977) there are several factors that seem to have a major influence on children's reactions to hospitalization. These factors comprise separation from parents, age, understanding of hospitalization and hospital procedures, interpersonal relations, the Hospital environment, and others.

1. Separation from parents and the age factor. A great deal of research has shown that the separation from parents arising from a child's hospitalization can contribute to immediate and long-term emotional distress. Children, like Billy, are more vulnerable to emotional upset than older children. Bowlby (1978) suggests that most children exhibit a strong attachment period until almost the end of the third year and after that are better able to accept mother's temporary absence from a strange place, although the mother usually remains the central feature of the child's environment. However, he stresses that such feelings of security are conditional on such factors as having a familiar subordinate attachment figure present, not being unhealthy or not alarmed, and being aware where mother is and that she will resume contact at short notice. In other words, he is suggesting that such conditions as ill health and pain, and the occurence of alarming events, all activate attachment behaviour influencing the form it takes and the intensity with which it is exhibited.

2. An understanding of the hospital environment. Because Billy had never been in Ward 7 before this intensified his loneliness, grief, and confusion. Due to the emergency of his condition, there was not time to prepare him by, either a pre-visit to the ward which is always welcome, or through explanations by his mother. this reinforces, in fact, the importance of there being no sudden break from the parent and also encouraging ward staff and doctors to be more understanding with regard to the importance of having an induction process.

3. Interpersonal relations. The importance of interpersonal relationss in the care of Billy and other children in the ward should be stressed. This is especially important with regard to the staff-parent relations which influence the emotional well-being of the hospitalized child. I shall elaborate on those relations later when discussing the the importance of effective communication.

Apart from staff-parent relations, others of importance are those of the staff and child as well as the staff to each other. Some of the views expressed by the nursing staff in caring for their young patients have already been touched on. The medical staff in general also seem to be extra sensitive when it comes to treating these children of Ward 7. In the words of one of the paediatricians:

"I don't think that people realize and acknowledge the difference between a child patient and an adult. Adults can usually understand what you say and obey your requests providing you communicate clearly. Children, however, are quite a different ball game. I try and keep children out of hospital as much as I can, especially the under six year olds. These kids are separated from their parents and subjected to horrendous experiences. It's bad enough to take them out of their home into another house let alone a hospital. Some cope much better than others and there is no post-hospital period of behaviour whereas others are distressed and hard to handle. Others again are apathetic and don't complain during their stay but give their parentsstressed and hard to handle. Others again are apathetic and don't complain during their stay but give their parents hell when they get home."

According to a surgeon:

"If a child is very ill I become extremely emotional and over-anxious to make sure things are going right. If the end result is a child that can run and sing and laugh again the whole exercise is very rewarding. There are no hangups and children recover rapidly because they set their own rate of recovery."

One of the general practitioners had this to say:

"Children are so different to adults. With adults you can go through the motion and routine but with children I always have a higher degree of awareness. You don't only have to watch you don't miss anything in the child but you've got to pick up what's going on behind the scene at home."

4. The Hospital Environment. In the views of Klinzing and Klinzing (1977) recreation, play and educational opportunities are important remedies in providing the hospitalized child with an outlet for his emotional stress and upset. Winnicott (1974) regards play as universal and a healthy activity; it facilitates the development of personal identity and the capacity to relate to others. As I indicated in the layout of the ward, Billy has the facilities to distract him from his asthma and provide him with pleasant experiences during his stay in the ward. The Charge Nurse held that:

"To play in this ward and especially in that big playroom outside is of the utmost importance. It gets rid of all the traumatic experiences and anxieties that build up. We certainly encourage it to the fullest because it helps them feel more relaxed, comfortable, and free to communciate."

5. Other Factors. Various other factors may influence the child's reactions to hospitalization, such as the length of stay, nature of the illness, intelligence, and previous experience within the institution.

Staff, Parent and Child

The preceding information about Billy's experience in the Hospital serve to indicate the nature and extent of emotional upset. If the threat to Billy's emotional well being is to be reduced or eliminated I have to take a closer look at the

relations between the staff, the parent, and the child. The key to these relations is effective communication among the various parties which in turn can significantly influence the emotional climate of a child like Billy. As I have already indicated the primary need for Billy is for a warm, intimate and continuous relation with his mother; or if that's not possible, a mother-substitute like his Mothercraft Nurse. However, it is also a question of how the relations between his mother and the doctor as well as the nurse, effects his behaviour. If mum feels calm, secure, and not duly worried, Billy will sense that, and that in turn, will influence his own feelings and behaviour.

Relations between doctors and mothers.

Most of the medical staff at the Hospital have the opinion that you cannot diagnose Billy unless you involve his mother. One general practitioner who is seen quite often on Ward 7 explained:

> "You are dealing with a double barrel patient because you can't isolate the mother. I don't see the child as a single patient but as an extension or part of the mother. You examine children like a vet and look for physical signs and get most of the story from Mum. How she tells the story determines the sort of answer you give to the mother. That is, how you perceive the mother's fears or the mother-child relationship. Children vary enormously depending on how they relate to the mother. There is always this undercurrent going on with the mother. If father then comes in as well and if they disagree it becomes a quadruple problem and can lead to real conflict. It's like a sandwich with the child in the middle. Very often the parent should be the patient and not the child."

One of the surgeons had a similar view which he put succinctly:

> "When I examine a child I feel like a vet with no history of that patient but mother tells us everything and I simply act on that."

In the words of a paediatrician:

> "To be a good paediatrician you should first of all like children. But you must also have a social conscience because so many social issues we are faced with here in the ward alone are family problems and not children's problems. Because the parents can't adquately handle the social problems they use the Hospital as a temporary rest spot.

When asked whether there was any difference as far as the socio-economic background of the parents was concerned he said:

> "The socio-economic background varies as to the problems they present. The more affluent the parents the more they present me with anxiety provoking things. The working class seem to be more capable of coping; not all of them, of course. Those that give love and affection and do it extremely well or badly are present in both camps. I vary my communication system accordingly."

The Resident. A major worry which seems to be consistent throughout the Hospital by various staff members is the inexperience of the Resident Medical Officers, although there are exceptions. This concern is especially levelled at those in the earlier years of their training because of its affects on patient care. The situation in Ward 7 is similar to what I described in Ward 1.

The situation is a constant worry to one of the paediatricians who remarked:

> "The difference in intelligence and attitude between the

RMO's we get in this Hospital never ceases to amaze me. With some I'm really impressed by their skill, interest and ability; they are right on the ball. But many others are the biggest slobs you could come across. How they get into medical school is a complete mystery to me because they are lacking in plain intelligence, common courtesy, and even humanity. Some have absolutely no interest in paediatrics and are probably better suited for surgery (laughter). To be a reasonable doctor you have to have a fair degree of humanity in the broad sense. That is, you've got to have some ethos. Some of these youngsters worry me a great deal because they're into their Alfa Romeos and their beach houses along the coast."

A similar view was expressed by a Mothercraft Nurse: "Sometimes I become very frightened and frustrated when I see that a young child is not well and you know is deteriorating but the RMO can't detect it. In the end I get so concerned that I have to talk to the Charge Nurse and she then takes care of it. I know we all have to learn. It's the uncertainty and the lack of experience that worries you. Also you can tell when they are interested in children or not. Some don't even come on the rounds or follow up if the kids are o.k. let alone play with them a little bit. We had one chap here who was absolutely lovely. He'd always pop back to see the children and play with them for a while. But that's rare I can tell you."

Relations between nurses and mothers

The Charge Nurse and her team in Ward 7 have been trained to care for a parent-child unit and just an isolated child. They play an upholding role towards Billy's mother and understand the reasons for her presence even though this puts additional responsibilities upon them. The emotional tension of the parent is a major problem which has to be recognized and carefully managed.

The relations between the nurse and his mother can greatly affect Billy since he is the reason for their relation. If there is suspicion and hostility Billy will be affected. In his case there is a great deal of mutual respect and trust which makes that little boy feel loved and secure because he can sense that Mum is not over concerned. When a nurse shows respect for the parents, the latter usually respect the judgement of the nurse. Some nurses will in fact go out of their way to learn from the parent about the child's personality and individual needs. This means that Mum is welcome on the ward and at the bedside of the child and encouraged to continue some of her normal and important mothering tasks such as feeding and cuddling. For nurses to establish this kind of sharing relation with a mother, they have to reckon with the mother's own distress. For the mother to able to care for her own child, is itself a help to her.

> Billy's mum, sitting near his bed, said to me:
> "When I first arrived here that afternoon with Billy I was so upset I couldn't even think straight. It's amazing how dependent you suddenly feel on others who can help your child. That's all you think about in that moment. When I came to see him after tea I was made very welcome and was amazed at the friendly atmosphere and surroundings. No one harasses you here and I'm grateful for that attitude towards me. The only problem is that I'm a bit stressed because I can't be here as often as I would like to due to my domestic commitments to my other children at home."

There is no restriction on visiting time and parents are left to decide for themselves how much they will visit. They are also encouraged to do much of the ordinary care. Mothers who are allowed to visit freely will remain realistic in their view of the child, thereby sustaining their self-esteem. Since this close relation is maintained the transition from the Hospital to the home will be greatly eased (Robertson 1970).

However, the relations between the staff on Ward 7 and the mothers of other children are not always as harmonious as with Billy's mother. Some mothers display various problem behaviours which can be very stressful for the nurses. Some of these problems are, for example, the inability to leave the child caused by separation anxiety, lack of confidence in the staff or guilt; the difficulty in managing their child's behaviour and giving in to its demands; becoming overprotective which can be irritating to the staff and stifle the child; complain continuously, which is a behaviour that is quite usual; or infrequent visits and/or interacting very little when they do visit. (Klinzing and Klinzing, 1977.) These behaviour patterns sometimes lead to conflict because the nurses resent playing waitressing roles to the mothers which causes a constant undercurrent of tension.

Whatever the problems, it is not easy for the nursing staff to have "strangers" constantly present in the ward. Mothers, in turn often feel lost and don't know how to play the role of "mother-in-the-ward" which is quite different to that of "Hospital visitor" (Stacey et al., 1970).

The Charge Nurse in this ward has the task to manage and coordinate an additional member to her role set. It is another discontinuity in the system and thus another boundary. Her task is to see that she and her staff play a supportive role towards the mother and leave some of the routine care of the child to the mother. The latter is regarded not as a rival or a

complication but as part of the child's treatment. Discussing the role of mothers on her ward, the Charge Nurse said:

> "The mothers on this unit vary quite distinctly in their behaviour. Some are so thankful and hold your hand. Others again are so quiet and gentle that they don't say anything so that you've got to draw everything out of them. The ones I can't stand are the dictating and abrupt ones. They just sit there and watch the serials on T.V. and irritate the Mothercraft Nurses. Dealing with these difficult types can be very draining on the caring. They all care somehow for their kids but it varies in depth. If they get too stroppy I have to step in because it affects my staff. Unfortunately, the kids then turn against us. But you can't have mothers managing us. They should assist us so that we can work together not against each other. With a bit of patience and communication we usually get cooperation."

The relations between mothers and the ward are complex and contain ambiguities. They can be conceived in three ways. In one, the mother is physically present but stands outside the boundary of the work system of the wards. In the second, the mother is co-opted into the treatment team. In the third, both the mother and the child are seen as a pair to whom the ward staff relate. In this case, the situation mey be regarded as an area of overlap between the hospital and the family. Individual nurses and mothers may not share the same conception, which makes for confusion and conflict. Such differences in conception will be apparent in the next chapter about the maternity wing.

Of all the various aspects of their stay in hospitals, patients are usually most critical about the problems they face in obtaining satisfactory communication. In the case of Ward 7 it is the parents of the children who provide and seek authorative information about the treatment, progress and aftercare of their children. According to the Charge Nurse, parents of higher

occupational status tend to inquire much more about the condition of their children and gain more personal satisfaction from the interaction with staff than those from lower socio-economic backgrounds.

Because the parents are outsiders as well as visitors it is vital for both the parents and the Hospital that a satisfactory communication system be maintained. If communication is to function effectively as the key to providing emotional care for children, like Billy, it is essential that all staff who come together on the ward be skilful communicators. It seems to me that on this ward the staff have the knowledge to give satisfactory answers to the clinical issues at hand as well as provide the ease the parent's anxiety knowing that the confidence of the child depends on the degree of security he senses in his parent.

IDENTIFYING THE CONFLICTS

Conflicts in Ward 7 arise mainly at the individual level focusing on intrapersonal conflict and conflict between individuals of different specialized areas and socio-economic backgrounds. According to the Charge Nurse there is a great deal of panic and anxiety on behalf of the medical staff with regard to the diagnosis and treatment of some children. This mainly relates to the residents who lack the experience so essential in the treatment of children and try to avoid it by the over-treatment of the patient. It is an example of an intrapersonal conflict caused by uncertainty as to what work is to be performed, a special variant of a task dilemma. This uncertainty affects the nursing staff who are then put into a position of confronting the resident or forcing the issue by approaching the Visiting Medical Officer. Conflicts at one level are therefore linked into conflicts at another level.

Mothers, at times, also face a true task dilemma. Billy's mother, for example, felt rather frustrated because she was caught in the bind of trying to visit her son as often as possible and yet feeling guilty that she may be neglecting her domestic duties and caring for her other children at home. Her only way out of this situation is to compromise so that nobody in her family feels unloved and neglected.

At times, a child is admitted to Ward 7 whose illness requires the treatment of several different specialists, which results in a crossing of boundaries in the managing of the little patient without anyone wishing to take overall responsibility - a clear instance of organizational ambiguity. The Charge Nurse and her staff are often caught in the middle with orders or expectations from one medical staff member clashing with orders or expectations from another. This results in a stressful and frustrating experience for the nurses. Fortunately, for all the parties concerned, including the vulnerable patient, a consensus

is usually reached whereby the issue is resolved in a mutually satisfactory way.

There are instances of orientation differences, not only between members of staff, but also between staff and mothers. The nurses find themselves occasionally in conflict with the mothers of the children who are admitted to the ward. As indicated, some of the mothers display various problem behaviours which can be rather stressful for the nursing staff. The reactions to these interpersonal disputes can vary on the part of both individuals depending on their personalities and background. Because most children only stay in the ward for short durations, most nurses will avoid the issue by remaining neutral or suppressing the conflict in a diplomatic way. This smoothing technique is particularly useful because the preservation of the relation between the mother and the nursing staff is so very important.

Other nurses, on the other hand, will force the issue into the open by standing up for their rights and defend their clinical or formal authority on the ward against a mother's behaviour which can be harmful to the welfare of the child. Unfortunately, the conflict often remains unresolved leaving bitter resentment and a lack of cooperation and committment to the solution. In those cases, the Charge Nurse steps in and tries to find some sort of compromise through the process of negotiation.

In writing of this chapter and reflecting on my experience in the Childrens' Ward I was aware that the degree of conflict in this ward was not as high as in the other wards and the Operating Theatre Suite, and the antecedents not so readily visible. It is perhaps not so much that they were not present, but that the conflicts were being better managed. This is due not only to the vulnerability of the patients, as mentioned by the Charge Nurse, but also to the lower degree of orientation differences.

CHAPTER 15
THE "PATIENT" IN THE MATERNITY WING

INTRODUCTION

This chapter highlights some important and interesting phenomena which are all interrelated and have a strong bearing on the journey which a woman undertakes to reach patienthood and parenthood. The phenomena in question include the meaning of pregnancy; the authority and control of the medical staff; the relation between women and their doctors; the increasing assertiveness of women in society today; and the reaction of some midwives, mothers and the community to increasing technical intervention in delivery.

As indicated in the last chapter on the children's ward, the "patient" in the maternity wing can also be conceived in different ways. In one, childbirth is treated as if it were an illness. In another, it is regarded as a natural process. Another difference is between treating the mother in the interests of the baby, and relating of to the mother and baby as a pair.

Pregnancy and childbirth are normal states of transition both socially and biologically. They are also ambiguously placed on the boundary between illness and health leaving their meaning open to different interpretations and hence contrasting styles of management. These contrasting perspectives are expressed in often confusing and contrasting guidelines for role behaviour relating to pregnant women. The obstetricians and gynaecologists at the BBH perceive childbirth as "pathological and scientific" whereas midwives and some lay persons perceive it more as "physiological and natural".

It has already been made quite clear that the doctor has the power and authority to define what is and what is not illness, together with what is and what is not appropriate behaviour in a patient. The doctor-patient relation is a power relation; no matter how assertive the individual patient, it's the doctor who is in charge and who has the ability to define and to make decisions. It is usually the professional who wins the war and the patient who capitulates.

In the Hospital, pregnancy and childbirth are usually subject to medical definition and control which is generally seen in the idiom of illness and thus subject to technical intervention. The ceding of control ny the mother to the doctor often begins with the diagnosis of pregnancy. In fact, this control has been interpreted as the exercise of dominance on the part of a predominantly male profession over women in general (Richmond, Bedford and Goldthorp, 1974). Women have traditionally been passive in their relation to doctors which has only reinforced the patriarchial and often condescending attitudes of the medical staff who ignore and trivialize women's concerns and physical symptoms calling them emotional or neurotic.

Doctors are important to women both symbolically and in real life. The latter are dependent on them and medicine for the most basic control of their own bodies. It sometimes seems that the power of reproduction - having a baby or not - is as much in the doctor's province as it is in the mother's (Roberts 1985).

At the BBH, as in most other hospitals providing maternity care, there is widespread medical intervention in childbirth. The operative obstetric rate at the Hospital fluctuates from year to year, sometimes reaching 25%. This is an issue over which there is a great degree of conflict. The midwives regard the figure as much too high but the doctors are adamant that this intervention is necessary, and is based on their knowledge and expertise.

A survey conducted by the Australian Consumer's Association magazine, Choice (May 1988) found many women were upset and even bitter at not being able to deliver their babies naturally. Instead, they were being subjected frequently to practices including caesarian sections, artificial inducement of labour, epidural anaesthetics and forceps deliveries. Some of the obstetricians and gynaecologists at the BBH give the impression of being sympathetic to the wishes and needs of many new mothers, especially those under private health care. Others, on the other hand, state that some mothers are not aware of their true condition and what needs to be done. To some midwives and mothers, however, this appears as a willingness to "wield the knife" and to ignore the expectant mothers' requests, which are interpreted as being due to impatience on the part of the medical staff, compliance with hospital routine, shortage of staff, and the doctor's preferential treatment of private patients. As a result many women are being transformed into "patients" with the connotation of passivity implied by the word and midwives who have been influenced to play a less significant role than the used to. Even those midwives who do question certain medical decisions are soon put back in their place, thereby denying their traditional clinical skills to the mother.

In the U.K. for example, lay pressure groups came into focus in the early 1970's, expressing their views that women should have the right to freedom of choice as to where and how they give birth. One of the earliest is the National Childbirth Trust (NCT), an educational charity involved in education for parenthood. Its objectives are to promote the mental and physical health of expectant mothers, aiming to boost their confidence in giving birth. To this end the Trust provides information and support to parents, and works directly with health professionals. Information is provided to parents on the process of birth, obstetric procedures, drugs and their effects, and the importance of breast feeding.

THE MATERNITY WING

The Maternity Wing or Obstetrics Service is a separate and fairly physically distinct section of the BBH called Stanistreet House, handling its own admissions and discharges. The primary function of this service is the delivery of the perfectly formed live baby with the mother unharmed as well as the provision of high standard medical and nursing care. The secondary objective of the service is to create and maintain an environment and pleasant atmosphere conducive to the attainment of personal, family and social expectations of childbirth.

The task is differentiated by time into three phases: ante-natal, delivery, and post-natal. The physical structure clearly reflects this differentiation. The clinics where the ante-natal examinations are carried out are not in Stanistreet House but are located in the Casualty Section of the main Hospital area. Stanistreet House comprises two major sections. The wing comprises two major sections, namely the Delivery Unit, which is located on the fourth floor and the two Post-Natal Wards. One of the latter, Ward 14 (19 beds) is on the second floor housing public patients; the other Ward 15 (21 beds) is located on the third floor used for private patients. The Post-Natal Wards also hold women who need special ante-natal care.

The mix of patients admitted to the two wards consists of antenatal, postnatal and gynaecology with their varying degree of complications. The workload on Ward 14 has increased considerably due to a high percentage of patients from low socio-economic backgrounds, drug abuse, early teenage pregnancies and various other social problems.

The bed occupancy and the number of deliveries varies from day to day with the former being much lower than in the rest of the Hospital.

In this Maternity Wing setting there is ongoing confrontation between the two major identifiable professional groups, namely the obstetricians and gynaecologists on the one hand and the midwives on the other. Generally speaking, the two groups express different perspectives on the reproductive process and of their relation to it. The perspectives provide a basis for their ideological and political confrontation whereby each group attempts to defend or increase their territories. Moreover, there are also occasions where the pregnant woman herself clashes with her doctor or other professionals on the ward due to different images or just plain ignorance concerning pregnancy and childbirth.

THE DELIVERY UNIT

One enters the Delivery Unit facing a corridor separating four delivery rooms on the left hand side and a wash room, two change rooms, charge nurses office and two preparation rooms on the right hand side. The floor does not provide an intimate atmosphere as it is too open with all the equipment and facilities in full view. Moreover, the rooms are small and clinical. Moves are afoot to provide a more homely atmosphere by carpeting and wall-papering the delivery rooms as well as installing lights with a much softer glow. All deliveries are carried out here except caesarian sections.

The hospital also intends to establish a Birthing Centre next year in which expectant mothers will be able to deliver in a domestic rather than a clinical atmosphere. This would be something like a halfway house - half way between a hospital and a home birth. It is hoped that the Centre will offer a reasonable compromise in the simultaneous satisfaction of physical and emotional needs.

The Charge Midwife and her team

The Delivery Unit operates twenty-four hours a day covering three shifts and its management is in the hands of the Charge Midwife. The latter is reponsible to the Assistant DON and ultimately to the DON on nursing matters as well as giving assistance or coordinating the activities of the medical and paramedical personnel who have responsibilities in the Unit. Her staff consists of six permanent registered midwives (four full-time and two part-time) and five nursing students.

The Charge Midwife is of paramount importance because she plays the central role in this labour ward. She makes many critical decisions and must often decide when the limits of her authority are reached and then seek consultation. This all gives

her formidable responsibility which requires many years of clinical training and administrative ability.

She is in her forties with wide experience in obstetrical nursing as well as sound leadership and co-ordinating skills. She is a woman who is extremely dedicated to her job devoting a great deal of her time to women in labour and gaining great job satisfaction in helping them to overcome maternal stress. All this is clearly reflected in her comments concerning her job:

> "I see myself as playing a crucial role in running an efficient unit which prepares women for that important occasion of delivery and bonding which is so vital. The Delivery Unit is where I want to be because it's so fascinating and satisfying. This here is really what life is all about and I'm in the middle of it all. Women are all different and interesting and you also get to meet the fathers and the family thereby observing the complex relations that occur. I become very involved with mothers and their delivery and try to assist as much as I can. Often it's just a question of being there that is important."

When asked about any frustrations in the job, the Charge Midwife replied:

> "My biggest problem is too many interruptions and being asked to attend several things at the same time by people from all different departments of the hospital. I'm lucky to get my administrative tasks done let alone see my patients. What frustrates me abvove all is the apathy on the part of the medical staff relating to midwifery. We have enormous opportunity to develop here and yet we don't seem to get anywhere. I'm often completely drained in having to fight for everything that you want from all areas of the hospital but you just don't get through and there is never any feedback from administration."

A good Delivery Unit depends on efficiency, humane conditions, and a team spirit of mutual trust which are vital components of care in labour. Expectant mothers need to feel safe in the sense that the medical and nursing staff who they have put their trust in behave as members of a team. It is only with a positive team spirit that the Delivery Unit can begin to function smoothly and effectively.

> The response of the Charge Midwife on this matter was: "One of my main responsibilities is to build a cohesive team where mothers feel secure in the belief that we are all professionals acting out our roles for the benefit of the mother and her child. We have a happy atmosphere on this floor as far as the nursing team is concerned. Harmonious atmospheres are always created by those at the helm as well as the provision of an open line of communication. I deliberately make it relaxed because I don't stand on ceremony. I feel that I am respected by my staff because we do things together and support each other. We hear good reports from consumers and get many letters of praise and gratitude."

Relations with the medical staff

Being in charge of the Delivery Unit and having the responsibility of building and sustaining an effective team should mean that the Charge Midwife be given the recognition and support not only of the nursing staff but the doctors as well. The visiting medical staff serving the Unit at present consist of four obstetricians, two paediatricians and fifteen general practitioners as well as the senior registrars.

Although the standard of care in labour is high there seems to be conflict not only between the medical and the nursing staff but also within the ranks of the doctors themselves. This often results in a lack of clear direction from the top and a general

apathy as to the interests of the midwives and their development. When questioned about this relation with the obstetricians, the Charge Midwife replied:

> "Generally, I find most of the obstetricians rather apathetic to our cause and development by showing very little encouragement or interest. We have to fight for everything we want and are rarely consulted as to what is right for mother and baby. But we are fighting back because the little gods no longer tell us what to do and expect complete submission. Thus they feel intimidated, claiming we are encroaching on their power base and the right to control. Consequently, they don't get involved in our ante-natal classes and very seldom turn up to our midwifery meetings. When they do, very little is achieved which frustrates me no end. Even amongst themselves they don't seem very cohesive. The head of the department has no influence and one obstetrician in particular can't stomach one of the paediatricians. It's a real pity because, overall, the attitude of these doctors can make all the difference to the running of this place."

On apathy one of the obstetricians made the comment:

> "To say that I am apathetic towards midwives is absolute nonsense. However, there is no doubt that I have the right and the expertise to be in control as far as the management of labour is concerned. I also make it my business to always check up on the level of competence of the nursing staff under my command before taking on a delivery. There are times, of course, when I do listen to the suggestions of the Charge Midwife and especially to the needs and interests of the mothers."

Another said:

"I think midwives certainly play an important role throughout labour but I don't regard them as qualified enough to take the sole responsibility for the delivery even in normal cases. After all, if something goes wrong in the last minute I'm the one ultimately liable. In fact, the whole issue of child-birth and women's rights and what have you has become quite ridiculous. It really all depends on what the community wants as far as the level of expertise is concerned and the amount of risks they are willing to take. I am equipped to handle any problem"."

Towler and Bramall (1986) raise the question whether parental choice of the physiological process of birth is consistent with professional judgement and accountability. If a mother is to accept responsibility for decions she makes regarding her labour and delivery, then that choice must be a very well-informed one. It is up to the doctor to provide an objective review of the whole gamut of possibilities relating to each particular obstetric situation. The mother, on the other hand, must be required to be happy to accept responsibillty for her choice having considered all the pros and cons, facts and facets of the matter.

The midwives at the BBH argue that many women allow their doctor to choose for them. Moreover, if they are given a choice then the alternatives presented are outlined in such a way by the obstetrician that they show up the negative side of childbirth. In other words the best choice to be made is the one leading to technical intervention.

THE "PATIENT": JUDY

I shall take the example of a young woman by the name of Judy who is to be admitted to the Delivery Unit at the BBH to undergo normal delivery of her first baby. This particular first pregnancy will enable us to gain a better insight into the important transitional phase from childlessness to parenthood.

Psychologically, pregnancy is a "turning point" - a time when the women is faced with the huge developmental tasks of becoming a mother (Klaus and Kennel, 1982). The passage marks a transition in social status by placing her in a marginal position with specially important implications for her self-concept (Hart 1977; Comaroff 1977). The description here is once again confined to one patient career set in the context of encounters between the patient and the personnel at Stanistreet House.

My choice of Judy was made under similar circumstances to the other two cases. My request for spending time on the Delivery Unit was granted by the Charge Midwife. She also suggested that I interview Judy and Allen and also ask their permission to witness the birth. The couple were booked to come in next week and she felt that because they were of similar background to me, it might be easier for me to make a contract with her.

Most of what happened to Judy prior to arriving at Stanistreet House, was related to me later by Judy and her husband.

Judy and her husband, Allan, are both high school teachers by profession and come from a middle-class background. Judy who is in her middle-twenties and healthy, had never been to hospital before. Now, as a private patient, she finds herself being initiated into two new statuses, namely parenthood and patienthood. The paradox or conflict in this situation is twofold: parenthood is instigated and controlled by Judy herself thereby ascending to a higher status or social responsibility;

yet at the same time, patienthood is instigated and controlled by the hospital staff which results in her regressing to the subordinate role of patient. However, in Judy's case this contradiction is not so critical as was the case with her former cleaner, Donna, described by Judy and the Charge Midwife.

Donna was a public patient who had been given epidural anaethetics by the Senior Resident who then delivered her baby with forceps. She then spent several days in Ward 14 on the Second Floor. This girl was much less knowledgeable about the nature of childbirth, more diffident about expressing any sort of criticism and usually waited to be told by the staff on how to behave. In fact, she never even bothered to attend for antenatal care mainly due to apathy and the influence of her mother who had had six children and who knew best anyway. Thus, Donna was reduced to playing a passive role in an event entirely controlled by her doctor.

Regarding the type of women who are sent to the Post-Natal Ward 14, one of the social workers remarked:

> "The second floor accommodates public patients who are women from lower socio-economic beckgrounds. Many are single girls and teenagers who don't live at home and come from single parent families themselves. They don't attend antenatal classes but come to us because of their low self esteem and embarrassment. Once they leave the hospital we can't properly check on their behaviour they are so hard to track down. Mind you, it's not that the second floor is the only one where there are problems because it also happens on the third floor. The medical staff make out as if there are no problems there because they want to be in control of the mothers themselves and this makes me cross because many patients are missing out. I must agree however that the two floors are worlds apart. On the third you've got the smell of soap and powder, on the second you encounter some of the

moccasins brigade with fags in the mouth, tattoos on their belly and the goodness of orange drink to keep baby happy and healthy."

Judy on the other hand, has a completely different orientation to the important event. She has read a great deal about natural as opposed to medicalized childbirth and bonding and is only too eager to ask questions of her doctor and the midwives she encounters because she knows its her right of choice. She is also aware of the psychiological conflict going on inside her. When asked about her feelings on the subject, she replied:

"I view my first pregnancy with some ambivalence in that I shall be loosing my professional status because I really love my job which I find extremely challenging and rewarding. Yet, at the same time I really look forward with great joy and excitement to the arrival of this beautiful small being. I have a fairly clear definition of my condition and see myself as primarily healthy. If something minor should go wrong I shall leave that up to my doctor who I have the fullest confidence in. However, I am fairly certain that I will be the one who will play the major role in this happening and he is only too willing to let me."

Because of her satisfactory relation with her General Practitioner and her trust in him plus the fact that the birth is envisaged to be normal, Judy has decided that he would be a better choice to deliver her baby instead of one of the obstetricians recommended to her by a friend. The community is geared and educated to see a doctor at an early stage and medical confirmation is required for pregnancy to be formally recognised.

Judy is well aware of the high proportion of invasive procedures practiced in the name of the child with little evidence as to their real value. In addition, she knows that the birth of a first child is almost surely the most profound

emotional experience as well as being of paramount importance to all subsequent births. (O'Driscoll and Meagher, 1980)

Antenatal care

Once her pregnancy was confirmed by her General Practitioner, Judy began to attend regular antenatal care at his surgery. In addition, she enrolled in the Childbirth Preparation Classes held at Stanistreet House run by the midwives there. Allan also came along as often as he could which helped to prepare her for the birth and the subsequent care of their baby. At the surgery, the GP monitored carefully that Judy was fit and healthy for the birth and to detect any abnormality of pregnancy.

Judy was pleased that she had chosen this particular doctor not only because of his clinical expertise, but because she could talk to him about her needs and anxieties and was given patience, encouragement and support. In short, she was treated like a rational human being deserving of respectful attention and where both parties were concerned about the psycho-social as well as the physical dimensions of her condition. As her GP indicated:

> "I certainly don't regard pregnancy as an illness except in situations where there are medical or surgical complications such as diabetes, hypertension, kidney disease and so on. I try and establish a relationship where the woman's wants are met within the framework of safe sensible natural birth. They can make their own decisions where and how they want to give birth apart from the medical side."

According to O'Driscoll and Meagher (1980), the purpose of antenatal education should be to define a woman's role in labour and to educate her how to fulfill it. Moreover, it is also to convince her that she has nothing to fear and that she is quite capable of delivering her own baby. Antenatal education is essential of good care in labour and has an important bearing on the emotional stability of women in labour.

The obstetricians at the BBH pay lip service to the Child Preparation Classes but they do not get actively involved.

Labour and birth

The transition from the antenatal area to that of the delivery service represents a new rite of passage both spatially, symbolically and behaviourally. It is in the Delivery Unit that the climax of the "patients" passage to parenthood occurs - the birth.

After forty weeks, during which time Judy endured emotional ups and downs as well as bouts of morning sickness and fatigue, the long awaited contractions had begun and are now only minutes apart. Gathering a few belongings together including some baby wear Judy and her husband began the short drive to the hospital after having notified the doctor and the Admissions Office.

Arriving at Stanistreet House they both took the lift to the fourth floor where they were met by the Charge Midwife who informed Allen that he was welcome to stay in the Delivery Room during the period of labour and delivery. While Judy was escorted to the room, her husband set off to the Admissions Area. When he came back back from the Admissions Area, the Charge Nurse introduced me to them. I explained my research interest, and the fact that I had already witnessed the birth of my own two children. We discovered that we had friends in common. When asked if I could be present during the birth, Judy hesitated, looked at her husband who nodded. Then she shrugged, smiled and said "why not?".

When the time came I was called to the delivery room. I immediately began to reflect on my own experience at being present at my own wife's two deliveries and found very similar circumstances as the drama unfolded.

Judy came into the Delivery Unit well prepared because of the sound antenatal care that she had received. Moreover, she knew the place and it surroundings and was familiar with the faces she got accustomed to during the monitoring period. This all helped her to relax somewhat and this contributed towards a fairly less traumatic labour. It was an environment where she felt safe and important.

Factors which influence the progress of labour and the type of birth experienced include the physical environment of the room in which the labour and birth take place, the duration of labour, antenatal preparation, the relief of pain and the personal attention and moral support. (Lumley and Astbury 1980). They all have a significant bearing on a woman's emotional stability.

As soon as Judy arrived and elected to place herself under the care of her General Practioner and the midwives in the Delivery Room, for things she herself could not manage, their responsibility to look after her began in earnest. Her doctor who is ultimately responsible soon arrived to check on her progress and to determine when it was time for her to deliver. Before departing to monitor another case he commented to me:

> "You know, according to some of the obstetricians here I shouldn't really be in this room right now as they see themselves as the only ones who have the given right to deliver even if the birth is a normal one. They feel they should be here because they are the experts. Not only that, even if they were here the women under my care would be perceived as a purely medical case. They are all result oriented and if the baby is OK they've done their job. I don't think that the psychological aspect ever comes into consideration. In other words, what this women goes through emotionally is irrelevant; the end product is far more important. I regard the woman's expectations first and needs are very much part and parcel of the childbearing process. Obstetricians

should really only get involved in abnormal pregnancies."

These sentiments were later echoed by the Charge Midwife: "Most of the obstetricians I know have absolutely no empathy for women or feel for them as people. They treat them as cases in need of certain treatment or force them to play a passive part and only emphasize the negative aspects of pregnancy. Some need a real catastrophy in order to become a little more humane instead of being so arrogant and self-opiniated. I had a real clash with one of them yesterday who undermines my staff continuously by stating that they haven't got the authority to allow women any choice of labour. I know another one who wields the knife irrespective of the possible alternatives. I usually go to the patient in cases like that and leave the decision up to them. Childbirth in my view should be as natural as possible and I try to influence expectant mothers to have the same positive attitude. Anyway, they usually feel like we do and are on our side because they see us as the guardians of normal childbirth. Nevertheless I often find myself in a real bind between what the obstetrician wants and what I feel would be most beneficial to the expectant mother."

An Associate Charge Midwife had this to say:
"The days are gone when they used to burn us at the stake but they still try. As soon as we question something it is immediately seen as encroaching on their professional territory and they don't like it one bit. We are a threat to their power as we become true practitioners in our own right."

Judy continues to progress with her labour. She is totally in control and her body is adapting well to the process. To me she looks beautiful with slightly flushed cheeks and shiny eyes as

she glances lovingly at her husband who is sitting close by. Allan, wiping her forehead, whispers words of affection and encouragement. Although Judy doesn't quite show it, she has all the fears and expectations so common in women during this stage. As her pushing effort increases the baby is slowly coming down.

During this time the Charge Midwife and two other registered midwives have built a rapport with Judy in order to prepare her for the birth. All are mothers themselves which apparently seems to be an advantage as they are able to empathize better with her and show more understanding and sympathy for her condition. These are the most vulnerable hours of Judy's life when emotions run high and panic can break out at any moment. The Charge Midwife knows that she must keep Judy on a tight emotional rein and give her continuous personal attention and reassurance throughout labour. It's not just a question of monitoring Judy's progress but to establish the personal relation and tender loving care (TLC) so vital during moments of stress.

Suddenly the full blast of Judy's contractions return and it looked to me as if she was in real pain. She later told me that the agony was horrendous and not what she expected. Judy clenches her fist, closes her eyes and breathing deeply, breaks into a loud groan. She is barely aware of Allan's anxious watchful figure in the room. He feels quite helpless watching her suffer so and yet his presence alone keeps Judy in control and less panicky. To help Judy breath, one of the midwives places a mask on her face which gives some comfort and eases the breathing. Pain is such a constant feature of labour that without it the question of labour does not arise.

Judy senses now that the end is near and can be hastened by her own personal efforts. In the meantime her doctor has arrived and taken control of the delivery. After a while the head of the baby starts to come through, then the shoulder and the arms and then the whole of what now appeared to me as a beautiful little

creature. The General Practioner cuts the cord and hands the little boy carefully to the astonished and proud father. Allen gently washes him down in the little bath while the doctor is busy stiching Judy up who had torn during the ordeal. When it is over the baby is put on mothers breast who indicates her desire to hold and nurse him straight away. Feeling the tiny baby's soft and warm skin next to her, Judy beams triumphantly at everyone in the room and says quietly:

> "I think this is the best job that I've ever accomplished in my life and thank you all so much for your invaluable emotional and instrumental support."

Judy is especially thankful at the way Allan has supported her during the birthing process. He encouraged healthy activities, offered assistance and affection, listened to her fears and concerns and was always interested in everything concerning the pregnancy. Thus Judy was able to form a positive attitude towards the whole experience which in turn contributed to her feeling less anxious and depresssed then she would otherwise have been. Leifer (1986) indicates that the husband, in particular, is seen as a primary source of help for his wife. Satisfaction with pregnancy is associated with the exchange within marriage of affection and mutual inclusion. The less internal and interpersonal conflict with regard to fathers and mothers, the greater the satisfaction during pregnancy, labour, delivery and child rearing.

Parent-infant bonding

The initial bonding experience has long term significance because it is the beginning of attachments between a mother and baby. It is a maternal sensitive period where complex interactions between mother and infant help to lock them together (Klaus and Kennell 1982). They point out that among other determinants, bonding is affected by the behaviour of physicians, nurses and other hospital personnel; care and support during

labour and the first days of life; separation of mother and infant, and the rules of the hospital. According to the Charge Midwife it is an experience which stays with them for the rest of their lives. Thus she encourages "rooming in" or contact in the first hours and throughout the early postpartum days. It is also regarded as extremely valuable for the father to be there.

Judy and Allan were sharing this most precious experience together to learn about their baby and to develop a strong tie in the first weeks of life. In the words of Winnicott (1978:25).

> "This is the way the father can help. He can provide a space in which the woman has her elbow room. The mother's bond with the baby is very powerful at the beginning and we must do all we can to enable her to be preoccupied with her baby at this time - the natural time."

During the last decade or so a growing interest in the relation of the father and the child has become evident. That is, it is recognised that the mother-child relation does not exist in a vacuum but within the context of the family system (Bobak and Jensen 1987). Positive marital relations also influence the new mother's responses to her infant. The fact that Judy and Allen have a happy and harmonious relation has a positive effect on the attitude and behaviour towards the infant. Allan found it important that he was able to have an extensive early exposure to his son in the hospital where the parent-infant bond is initially formed. He indicated his feelings by saying:

> "I am terribly excited in being here and able to support and participate in such an intimate and important event. It has made me feel even closer to Judy and I'm simply over the moon with the little one to whom I feel so strongly attached already. The whole experience has had a very strong emotional impact on me."

Post-natal care

After having spent ten hours in the Delivery Unit, Judy was transferred to the Post-natal Ward on the third floor (Ward 15) where she remained to convalesce for five days. During that period she was well looked after with midwives carrying out routine observations and placing emphasis on the emotional attachments as well as her GP coming in to check her condition. While Judy was enjoying the luxury of a good earned rest, the infant was sleeping peacefully in a small bassinet at her side. She was allowed to have control over the care of the infant while the midwives acted as consultants.

The postpartum period on Ward 15 was giving Judy adequate time to interact with her baby. It allowed her to learn about his needs, become acquainted wih him, and be thoroughly satisfied with her own ability to meet these needs at the time of discharge. This close emotional and psychological relation between Judy and her baby is vital for the baby's complete development and well being.

IDENTIFYING THE CONFLICTS

Midwives and doctors

We have here a case of conflicts arising out of differentiation of function. The role of the midwife at the BBH should be seen in the context of continuing technological advances and increasing obstetric intervention. A great deal of the midwife's attention and time are directed toward the psychological and social needs of the mother, baby and family. She is an active helper who initiates encouraging and supportive behaviour and responds sensitively to the needs of he woman by bringing into play her female characteristics of instinct, intuition and emotion. Her attitude, example and actions can help or impede the attachment process between the mother and her baby. Teaching, counselling and demonstration of practical skills are dimensions of the midwife's role and are very important because mothers, like Judy, are perhaps theoretically knowledgeable but lack in actual know-how and practical experience. The role becomes even more important to girls like Donna who have limited or inaccurate ideas of the child-bearing process. In addition, many of the medical staff don't know how to communicate in layman's terms apart from always being in a hurry. The midwife is thus often used as a sounding board in explaining the womans condition or easing her anxieties.

Even though the midwives take a more responsible and active role in the progress and outcome of the birth they often find themselves in a role conflict. They are placed in a bind between what they know and feel another women's care should be and what they in their subservient capacity are obliged to do in fulfilling the doctors directives for the sake of professional interest. Some of the midwives will reduce the conflict by becoming the doctors assistant as "technological handmaiden". Others will behave more diplomatically by playing the doctor-nurse game (with suggestion and gentle persuasion techniques).

Whatever behaviour patterns are used, most of the registered midwives at Stanistreet House feel that their clinical diagnostic skills, knowledge and experience are being under-utilized and curtailed due to technological intervention and the condescending attitude of some of the medical staff. They see a devaluation of their role in the conduct of normal childbirth and a waste of resources in that they are not allowed to practice their skills without constant consultation with the medical staff. Many of those midwives feel insulted that they are not given the full responsibility for the whole task of looking after the normal birthing cases.

On the role of the midwife at the Hospital the Charge Midwife remarked:

> "We see ourselves as true practitioners in our own right who should be given the freedom to practice our skills to the best of our ability. Also, we should have a clear understanding of our individual role and there should be a close liaison between that role and the role of the obstetrician. This would enable him to spend more time with abnormal obstetric cases. At the same time this would create a partnership where our skills are used in the appropriate areas giving each one of us greater overall job satisfaction."

The doctors are sensitive and protective of their role which they perceive as the most prestigious and powerful on the basis of their expertise in the major task at hand, namely childbirth. They feel threatened, defending what they see as their right to make decisions which came solely within their specialist decision-making territory. In doing so, they continue to remind the midwives that by questioning their authority the midwives are in fact challenging this prestige be it rational or not. The cause of the conflict can thus be seen as a dispute over who is most skilled or who has the authority to manage the patients.

In most cases the medical staff use a forcing strategy whereby they use their superior power base derived from their authority, knowledge and skills to impose their conflict solution on the midwives. This type of strategy does not bring about agreement between the two parties and thus the resentment and the hostility continues to fester and the conflict remains unresolved.

Everyone suffers as a result. Mothers like Judy and Donna need to sense that the staff to whose care they are committed during this critical and emotional time, behave as true professional members of a team. Childbirth is a unique event which should provide a sense of profound and lasting joy and satisfaction for mothers in which professional and lay persons should share.

The management of the patient

Here we have a case of conflict due to differences in orientation to the therapeutic task. A whole task, as far as the patient is concerned, is the whole of the looking after of that patient and the responsibility for him or her. Managing that patient is managing the career of that patient through the Hospital. Thus the whole task of managing the patient is to be managing the varying states or needs of that patient through time and circumstance by bringing in varying degrees of intervention and support as neessary. Following Judy through the birthing process we could see that she had a number of encounters with the technical and the social system. A number of tasks were performed around Judy; some were looked after by her general practitioner, some by the midwives, some by her husband and others by herself.

There are two different conceptions of the management of the patient. In the first conception, someone takes on the patient and takes him or her through the system because they are a patient. In effect, what is happening is a sort of medical culture ethnocentrism in which the patient implicitly is given only a

passive role to play (Skipper and Leonard 1965). Taking over the patient role means taking away the patient's choice over things that he or she is quite capable of doing. Usually, it is for the convenience of running the ward, self-interest and for the protection of one's power base. Rarely is it for the true caring of the patient who is often left insulted, annoyed or frustrated. The fact that so much unnecessary technical intervention occurs in maternity cases at the hospital is said to be due to, not only medical necessity or the personality and capacity of the patient to manage, but sometimes for the sake of saving time and financial gain for the obstetrician. The primary task is not the caring of the patient in the true meaning of the word.

The second conception is that the person who manages the patient is the patient. It is he or she who is given the chance to be the most important actor on the stage. What is needed by the patient is the motivation, support and all the information necessary to carry out his or her own role. Because patients vary in their capacity to manage their own affairs they have to call on certain professional and technical services to do so which often causes conflict between these various forces. By choosing her doctor carefully and knowing a great deal about the birthing process, Judy was given the freedom to manage or control her own circumstances. Proper caring is giving the patient control of their own circumstances when they can take it and want it. If the patient lacks the capacity to manage his or her own affairs, like in the case of Donna then the whole of the looking after of that patient is in the hands of the hospital staff.

ANOTHER WAY: TROWBRIDGE HOSPITAL

I was aware that there are other ways in which patients are being treated and confilct are being managed. Trowbridge Hospital is a good example.

In February 1987 I visited the Midwifery Unit in Trowbridge Hospital. Trowbridge is a small country town in West Wiltshire near the border of Avon and within easy reach of Bath and Bristol The Midwifery Unit there is under the direction of the Clinical Nurse Manager (Matron).

The Trowbridge Hospital consists of a General Unit with 31 beds and a Midwifery Unit with 27 beds. It is serviced by four general practices with a total of eighteen general practitioners. Facilities include a twenty-four hour casualty service, a theatre, x-ray and physiotherapy department as well as consultants out-patient clinics which cover a whole range of specialities. Surgical consultants from Bath operate once weekly performing intermediate and minor surgery. The general practitioners are responsible for admitting patients but more serious cases are taken direct to the Royal United Hospital in Bath.

The Midwifery Unit

The 27 maternity beds service the whole of West Wiltshire although complicated pregnancies such as caesarian cases are booked into the District Maternity Unit in Bath which has the appropriate technical equipment and the professional expertise. Mothers also have the choice (usually after consultation with their general practitioner) as to whether delivery should be at Trowbridge or Bath. At the time of my visit, approximately 60% of the total admissions to the Trowbridge Hospital from the previous six months had been low-risk maternity cases. According to the Matron, those admitted comprise a good mixture of low to middle-class women. Many of these are single mothers.

The Midwifery Unit houses the Antenatal Clinic, the Labour Ward and Postnatal Care consisting of two wards and nurseries; the same arrangements as we find at the BBH. Usually women check into the clinic the same month and, once delivery has taken place, visit the postnatal care area every five to seven days. The Labour Ward is geared principally to normal birth or low degree forcepts deliveries and is organized on a three-shift basis. It comprises the Assessment Suite where there are admission rooms used for examination and monitoring purposes and the Delivery Room Area with all the necessary drugs and equipment. The latter is divided into two small and cosy delivery rooms and one large room called "The Ball Room". Apparently expectant mothers can book the one most to their liking.

Talking to the Matron about the Labour Ward she commented:
"Before I came here in 1984 there was no one in charge. The atmosphere was bad, the standard was quite low and the patients weren't at all very happy. I took the trouble to immediately upgrade the Unit by organizing and changing many things. For example, I had the Labour Ward nicely coloured which was white and cold before, bricked up the double doors which gave no privacy and tried to make the whole area more comfortable and homely. You have no idea what I had to go through to achieve this. People were annoyed, saw me as a threat and just caused havoc because it was against their principle. I had to literally fight for control every inch of the way."

This is a situation where somebody is in overall charge, and knows how to face the conflict she has produced by her initiatives to change things.

The difference between the maternity wing at Trowbridge as compared to the BBH is that in the former the women are cared for by the same group of midwives, whereas in Bendigo (as in Bath), each area has a different staff responsible to it. The staff in the Maternity Unit comprise twelve nurses of which there are five sister midwives, three staff midwives and four nursery nurses. The latter are responsible for the babies but are not experienced midwives. In addition there are five auxillaries who are not qualified and carry out non-nursing duties.

The midwives at the Trowbridge Hospital are regarded by the community as a well qualified multi-disciplinary team who are able to provide not only the clinical and practical skills required but also the social, psychological and interpersonal skills which are of special value to the mother. They are, to a large extent, independent practitioners in their own right who have the capabilities to enable women to harness their own inner strengths and confidence to enable the child-bearing process to take place unimpeded. In other words, women are given the choice to manage their own affairs during the stages where they are capable of doing so. Discussing this with the Matron she replied:

> "When I arrived here the nurses would lay down the law as to what is to be done with the patient, some in fact were quite outmoded in their thinking and practical application and many lacked the less tangible qualities of patience and empathy to the mother's needs. Since I have been here I have made sure that we have a strong cohesive group of girls whose own needs are also being met and who keep up to date with continuing refresher courses as far as midwifery is concerned. Not only is it important to uphold the standards of care but we must also strive to see that the patient's wishes are adhered to. If there are different expectations between the two parties we try and avoid the conflict by compromising."

Overall, the relations between the general practitioners and the midwives is fairly harmonious although there are occasional minor clashes which can turn out to be somewhat awkward at times. The GPs are on call and are responsible for birth overall. They only come to the Labour Ward if there is a problem with the delivery, leaving the primary care-giving to the midwives. Besides, they are also more practice oriented focusing their main concern on their practice in town. Both parties respect each other's opinions and the atmosphere seems open and trusting.

'General Practitioner Obstetrics' as practised at Trowbridge could be regarded as 'Midwife Obstetrics' with the General Practitioner in support.

The boundary between the staff taking on the vulnerable patient and the latter being in charge, is managed with the same people but different technological requirements at the different stages of the patient's through put. For example, pre-natal examination and the delivery process are technologically quite different. In fact, one can compare the Maternity Unit in this particular hospital to that of some other hospitals by using the idea of Emery and Trist (1974) and their differentiation between the conventional system and the composite system of coal mining.

The conventional system is a complicated system with simple workmen. As we indicated previously, many hospitals use sophisticated technology coupled with a modern management approach in an attempt to build up a complex system around a vulnerable and passive patient.

The composite system on the other hand, is a simple system with complicated workmen. At Trowbridge we find a simple system and complicated patients and staff. We have a much smaller and simpler system with constant staff who are managing the whole task with the patient. They are managing the relation with the patient at the varying stages and bringing in varying degrees of

intervention and support depending on the patient's requirements. The staff like the system and so do the patients.

There are obviously philosophical differences between the two systems. There is nothing wrong if the hospital and staff take over completely the management of a patient and using a complex system if that person's needs are so great physically and psychologically that she cannot cope. However, when one has crossed that boundary of the individual being able to look after herself the simple system is intrinsically and philosophically more dignified. It is a system that respects the individual's capacity and right of control; that is, recognizing the patient as a person and not a clinical factor or subject. It is under such a system that an expectant mother will be more aware and fulfilled with a greater sense of well-being and self-esteem and thus enter motherhood with positive and loving emotions.

CHAPTER 16

THE OPERATING THEATRE SUITE: WORK AND SOCIAL ORGANIZATION

RUMBLINGS AND IMPRESSIONS

Whilst spending the time in the wards and in the cafeteria I kept hearing rumbles and comments of desperation about the low morale and the strained atmosphere of the Operating Theatre Suite. According to one of the surgeons:

> "A new militant, subversive and disruptive feminist element has infiltrated the nucleus of the hospital destroying the good relationship which had existed."

Everybody from the medical elite through to the paramedics, nursing, and portering staff were bitterly complaining about the new head of the unit and the steady wastage of well experienced staff. Apparently this newcomer to the scene had just taken over from the old supervisor who had been there for many years. The picture I could gather from the various remarks made, was of the new supervisor as extremely autocratic, abrasive in her manner and lacking the most basic communication skills, let alone the tact required for such a specialized area like the Suite.

Consequently, I became very interested to learn more about this so-called disruptive element because more and more storm clouds began to appear on the horizon as the days went by. As an outsider I hoped that something could be done. It seemed to be the ideal place to study not only because of the present climate there but because of its overall importance to the functioning of the Hospital. Moreover, there was something rather forbidding and mysterious about the place; something worthwhile investigating.

My first formal encounter with the senior staff associated with the running of the theatre complex was at a meeting of the Operating Theatre Suite Committee, having been granted permission as an observer by the Medical Superintendent (quite some time prior to my appointment to the Board of Management). I had no idea who was on the Committee or what to expect. At this stage my intention is only to give a brief account of my first impression regarding the proceedings. The function of the Committee is explained more fully at a later stage.

The room I entered was small, separated by a long table with the Medical Superintendent as chairman at one end with two medical staff members on one side and two nursing staff on the other, facing each other. After I had been introduced, the discussion began to centre on some kind of list being too long and such matters as over-booking, emergencies, starting times, and over-worked nursing staff. I soon realized that the meeting was about the booking of patients for operations in the Operating Theatre.

As the meeting progressed it became obvious that each side was digging its heels in, trying to convince the other as to their point of view and getting more and more emotional in the process. The heated argument centred on the assertion of the Director of Nursing and the Superviser that theatre lists were too long because surgeons were adding too many so-called emergencies plus going over extended time which was effecting availability of staff and instruments.

The Supervisor of the Theatre Suite seemed very concerned for her staff pointing out that they were over-worked and tired and that they needed a break which was not there. Besides, she said, it wasn't so much a question of emergencies being added but of doctors not keeping to scheduled hours set down for elective patients. One of the surgeons then became quite agitated commenting on the fact that the medical staff had also commitments outside in the rest of the Hospital, not like the nursing staff in

theatre. The Supervisor then replied, (rather upset) that her team were bending over backwards even at night in an effort to maintain the throughput. The argument then turned to the issue of theatre instruments with the Supervisor claiming that there were too many instruments not even being used. The counter thrust to that point of view by the medical side was that often the instruments were needed, that they do not really know what is available, and that really nobody takes an interest each surgeon's technique and the type of instruments required. This again was hotly denied by the Supervisor.

So, on it went without any major interruption from the chairman who was rather quiet during all this slanging match and it seemed to me rather incredible that such vital issues were debated in such a manner when it really was a question centering around the welfare of the patient. Maybe each faction had their important objective in mind but because of their tasks, domineering personalities, different professional background and experience, and perhaps self interest, no solution or compromise could be found to a problem which would most likely continue to fester and perhaps embroil the whole Hospital. And that is exactly what happened.

The whole issue centred on the question of who had the right to determine the choices. That is, it was a question of power instead of work arrangements.

A LOOK INTO THE INNER SANCTUM

Having listened and read about some of the problems facing the Theatre Suite, I decided to spend some time to look around as well as to interview a few key players in that separate small world of the BBH. Other hospital employees rarely venture in, and casual visits from outside the Hospital are prohibited. The Operating Theatre Suite seemed to me like a small society in which technology, diversity of personnel, specialization and inter-relations are all brought clearly into focus. A similar view is held by Canter (1984) who writes that operating theatres epitomize aspects of hospital activities to a more heightened degree than anywhere else within a hospital.

The observations that form the basis for this Chapter began early one morning when preparations were on the way for a hysterectomy operation on a middle-aged patient. Permission for my entry into this alien land shrouded in mystery had been granted a few days before by the Director of Nursing and the Supervisor of the operating theatre suite. I think they felt that something more dramatic may be too much for my senses, considering this was to be my first experience of witnessing an operation. Prior to entering the sanctum I made sure I had some knowledge of the geography of the place and some of the key actors who were participating in the play.

A nurse, acting as my guide for the tour directed me to one of the change rooms where I dressed myself according to the regulations in green attire - sterile gown, cap, mask, gloves, and shoe covers. No writing material or other foreign object was allowed to be brought into theatre. Later when my journey ended I found a quiet spot and quickly wrote down my recollections. So, after taking a big breath and feeling somewhat apprehensive, but excited, I was then led, via the main corridor and the scrub bay into Theatre 2. In the meantime, nurses and technicians dressed in green attire with cap and mask were busy setting up

the instruments and the equipment, ready for use. It seemed to me as if a stage was being prepared or set up, ready for the drama to begin.

Looking around the room, everything seemed spotlessly clean, well lit, and properly ventilated. The drama was soon to begin as I was given the nod that the surgeon and his assistant, a Registrar, had arrived and were "scrubbing up". The tempo of preparation increased mixed with the sounds of chatter and laughter. This then ceased somewhat when the woman patient who was to undergo the hysterectomy was wheeled into the theatre, draped in green. She was was strapped onto the metal frame. The anaesthetist had arrived by then, and began to administer the anaesthetic at the head of the operating table. I really felt for that patient because she seemed to be in a most vulnerable state, both psychologically and physiologically. Here was somebody asleep, completely in the hands of someone else who had complete control over her.

Finally the surgeon and Registrar entered the stage (apparently late). With a nod here and there, the star of the show sat directly in front of the patient. He was handed an instrument of some kind, someone signalled with a gesture, and the play began. All those masked actors seemed to know the particular role they had to play very well,and the synchronized teamwork that took place was an amazing event to watch.

As the operation continued and there did not seem to be any major problems, the staff began to relax more and started to converse a little. There was talk of a football game, and jokes were made about somebody's camping trip on the weekend. Suddenly, the patient began to bleed very heavily and all the attention was again brought back to the fullest extent to the person or "object" in the centre of the room. Although the patient could not move or speak, her needs controlled the situation and the atmosphere became rather tense.

Having completed his task, the surgeon chatted with some of the staff and then left the theatre followed by the Registrar (who had completed the sewing up), and a little later by the anaesthetist. The technician and the nurses were left behind with the former having lifted the patient onto the trolley and taken her back to the recovery room. The nursing staff remained to prepare the theatre for the next case. My guide explained to me that usually staff arrive and leave theatre according to their professional status (except for the anaesthetist who has to check on the patient). Years ago anaesthetists were not as highly regarded, status wise, as their fellow visiting medical officers. Today, however, they are considered on par due to the fact that their education is just as long and intense as that of the surgeons (although some of the latter don't quite agree on that point).

Having caught a glimpse of the sanctum gave me some idea of the various happenings behind the scene. It was now time to learn more about this place from a managerial and sociological perspective and to discover the reasons for the low morale, the resignations by nursing staff, and the various incidences leading to friction and conflict.

THE POSITION OF THE SUITE IN THE HOSPITAL

The primary task of the Operating Theatre Suite is to provide a series of special environments suitable for surgical procedure in the investigation or treatment of illness or injury.

The task boundary

Patients are brought here in a certain prepared state from different wards in the Hospital, something is done to them and they are then sent out again to recover. It is a whole task. The constraints are to investigate and treat as many patients as possible and to do this as professionally as possible. What actually happens to the patient whilst in the operating theatre constitutes a special event during his or her stay in the Hospital.

We can determine the boundary of the Operating Theatre Suite on a sub-systems level perspective by looking at the patient flow through the various departments in the Hospital pinpointing where there are discontinuities. This type of analysis can also be applied within the Suite itself. A patient needing surgery moves as "human material" in a sequence of stages through the Hospital and the Theatre Suite. The operative treatment is traditionally divided into three separate phases or stages: (1) pre-operative or preparative treatment prior to surgery; (2) operative or definitive treatment; and (3) post-operative or recovery stage after surgery. Following the flow we find the Suite sequentially in the middle between two other stages; that is, the patient is brought from the ward into the Suite and returned back to the ward after the operation. The process defines the linkages between the two organizational segments. The task flow is sequential, but the task relations between the two units are reciprocal.

The Operating Theatre Suite is differentiated from the rest of the Hospital because the surgical procedures require special knowledge and skill - a technological differention. It is territorially differentiated in that it is separate fenced-in unit on the first floor of the Hyett Building. The time differentiation occurs in that the theatres' work is carried out after the pre-operative stage in the ward and prior to the recovery period when the patient is back in the ward again.

Power

The Operating Theatre Suite is essential to the functioning of the Hospital to the extent that if its activities were to stop, the work flow of the total system would be strongly impeded. Consequently, the Suite has a high degree of power based on its centrality to the primary task of the Hospital. If the number of operations would drop drastically, for example, then the whole survival of the BBH would be at risk.

Because the Operating Theatre Suite plays such a critical role in the functioning of the Hospital its problems become critical for the whole Hospital.

MANAGEMENT AND OPERATION

> "The operating theatre is my livelihood; my bread and butter. So to me a good theatre suite is one that is managed well and it is running smoothly and efficiently so that it gets through a good volume of work with minimum complications. There should be no slack with instruments or equipment and people should harmonize as a team around the patient. The nursing staff must render the necessary assistance in a competent manner - knowing the equipment, the procedure and anticipating the next move on the part of the surgeon."
>
> (General Surgeon)

The management boundary

A complete operating system implies not only the existence of a boundary between its task and those of other systems, but the inclusion of its own control activities. This would mean a combined task and management boundary around the operating system.

However, in the case of the Theatre Suite, there are several crossing boundaries where the control activities do not coincide with the task boundary. Although the Supervisor is in charge of her unit the medical staff in complete control of the conversion process which is the operation on the patient. Within each operating theatre the surgeon is in complete control of his patient and has the ultimate responsibility for that patient. There is an access of power to the surgeon by virtue of his knowledge and skill. Others, such as nurse educators, maintenance staff, and domestics, are responsible to their respective heads of department. There may be task boundary, but it does not correspond with any management boundary. Some things are looked after by some people; other things are handled by other people.

Because of the inter-dependent nature of tasks performed by the respective sub-systems, friction can be created if there is disagreement between the Supervisor and the heads of the departments. At the moment the Theatre Suite is riddled with conflict due to the friction between the Supervisor and the medical staff operating in theatre.

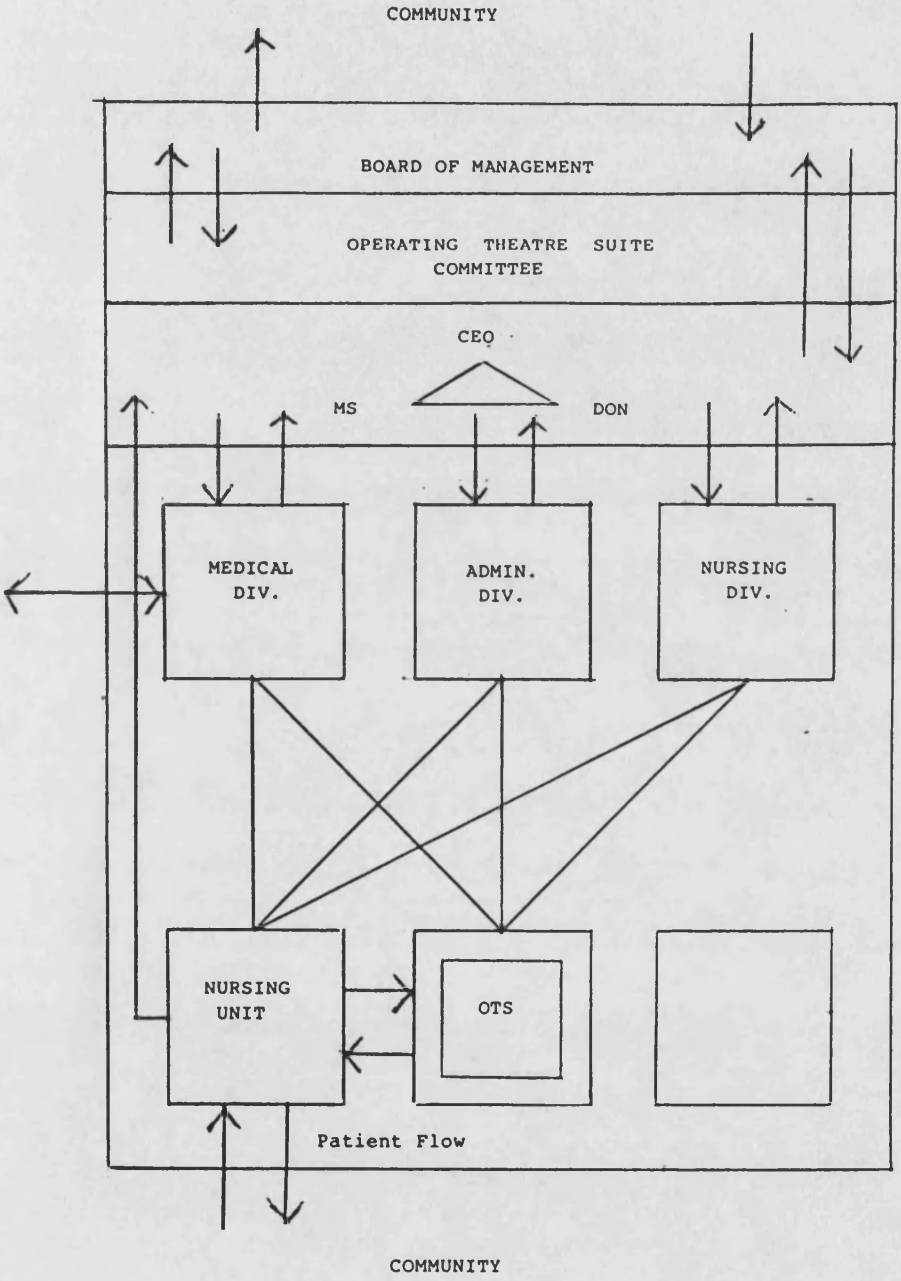
The ultimate responsibility for the function of the Suite resides with the Medical Advisory Committee. However, beneath this level the management situation is somewhat fuzzy which has resulted in a high degree of conflict, and problems not only within the Suite but in the Hospital generally. Aside from personalities no one is in clear control of this operating system because what seems to emerge are various patterns of control. Figure 10 depicts the organizational control of the Suite.

The Operating Theatre Suite Committee (OTSC)

Most of the policies relating to the running of the Suite are formulated by the Operating Theatre Suite Committee, comprising the Medical Superintendent (Chairman), the Director of Nursing, the Supervisor, three visiting medical officers and two members of the nursing staff. When the Committee was set up it was to meet once a month to consider such matters as theatre utilization, staffing problems and the use of theatre procedures. Ideally any problems that arise between the medical and nursing staff should be ironed out at this Committee. Where necessary certain matters are referred to the Medical Staff Group or the Medical Advisory Committee which are then passed on to the Board or Committee of Management.

Even though control is formally vested in the Committee, it is seen as rather ineffective because of its inability to cope with the problems facing the Suite. Important decisions are not made and even if they are, they are, apparently, not passed on or followed up. Not only does the Committee meet irregularly but the

Figure 10. Organization control of the Operating Theatre Suite.



Medical Division and the Nursing Division are represented by what seem to me to be some domineering personalities. But it is more than that: it is a conflict between occupational groups over power. Both camps have dug in their heels trying to protect their own self-interest revolving around the introduction of change and trying to get that change accepted.

The Committee requires an effective Chairman; somebody who is strong, assertive and yet diplomatic in forcing the issue or reaching a compromise. A Chairman, to do his job effectively must ensure that the group works together as an effective, cohesive group. Because the situation demands a multi-disciplinary approach to problem-solving and decision-making the Chairman must encourage participative behaviour on the part of those that are prone to autocratic leadership styles. The MS may not be forceful enough, but it is a difficult role to play because one is dealing with head strong personalities, power plays, a shortage of nursing staff and limited resources. Moreover, apart from being the Chairman of the Committe, the Medical Superintendent is responsible for the organization of an appropriate system of administration and control of medical services also embracing the Theatre Suite (except for nursing staff).

The Supervisor

The overall administration of the Operating Theatre Suite is in the hands of the Supervisor, a senior nurse, who is directly responsible to the Assistant DON and ultimately to the DON. She has the task of making adequate provision to ensure the highest possible standard of patient care in conjunction with the Suite. The job involves the functions of planning, financial management, personnel, maintenance, public relations, and staff development. She is assisted by the Charge Nurse whose task is the day-to-day running and staffing of the four theatres.

Because the Superviser is administratively in charge she has formal authority or position power over the nursing staff and "functional" authority over the rest of the support staff. Added to this is some degree of expert power in the area of clinical theatre nursing skills. However, she has no authority and little power over the medical staff who are the experts in their field.

> To my question of authority and power, the Supervisor relied: "Overall I really have very little power; theoretically yes but not in reality. My biggest hassles are with the doctors; some are real power brokers but I still have to assert my authority,. Some of the older ones are quite chauvinistic and see themselves as leaders and we girls do their bidding. But the days when women were to be seen and not heard and didn't leave home are gone. I'm responsible to Nursing Administration and to the OTSC and not to the whims of the medical staff. Most of the time they don't come to me but go to the Medical Super, the DON or the CEO. So what do I do? I play politics but I'm not very good at it. I try to allow others to make suggestions but it doesn't seem to work."

Relations with other departments

The interdependency of the Suite with other sub-systems in the Hospital and the diversity of specialized personnel contributing to its primary task, indicates the importance of other departments towards the functioning of the unit. We have noted that unit administration, medical, nursing, technical, and domestic personnel are highly interconnected serving a patient population in this particular clinical area.

The Suite is organized in such a way that these professional, semi-professional, and non-professional personnel in the group are members of that group as well as members of the larger group or division representing their function. Even though their

orientations are towards the Suite and they report to the Supervisor, (with the exception of the medical staff) most of them are responsible to their respective heads of department. However, the Supervisor is dependent on these departments or divisions for the functioning of the Suite.

The medical staff. The relation of the medical staff with the Suite is very important, even though they do not form a department as such. As we indicated earlier the visiting medical staff are not full-time members of the Hospital. In addition, although some of the surgeons are listed as a team in their own area of specialty (e.g. general surgery, gynaecology, orthopaedic), they work independently of one another and with little formal organization. The twelve surgeons and five anaesthetists have the knowledge for task performance in theatre based on intensive training and specialization. It is they who are the primary source of technology there, and who perform the basic work, related directly to the production of the service. The surgeons (who are intimately connected with the anaesthetists) not only secure the inputs, by booking patients needing surgery onto the theatre list, but transform those inputs by operating on that human material using standardized skills and knowledge. Being professional they also seek autonomy and freedom from tight control.

The Nursing Division. A strong liaison is needed between the Theatre Suite and the Nursing Division. Individual patient requirements affect the numbers, classifications and categories of personnel needed. The efficiency of the Suite is very much dependent upon co-operation and communication between the Supervisor and other nursing departments and units, such as administration, education, and the wards. Nurses also represent a source of knowledge and carry out many of the technical functions of the Suite.

The Admissions Office. Close co-operation is also required between the Theatre Suite, the nursing units and the Admissions Office. The latter is responsible to the MS and its task is regulating the flow of patients through the Hospital including the close monitoring of the theatre list relating to elective surgery. Charge nurses from the various wards are usually informed and aware of the planned movements of the patients and can thus organize their work accordingly. Problems sometimes arise for the Supervisor because of patients needing surgery arriving through the Casualty Department and not the Admissions Office. They are regarded as emergency cases and have to be added to the theatre list in the last minute.

Other departments. Relations with other departments in the Hospital are also important, such as the requisition of supplies and equipment from Pharmacy and the Purchasing Office; the need for the maintenance and replacement of equipment though the Engineering Department; and the necessity of keeping the unit clean and sterile with the help of the Domestic Services Department.

TASK DIFFERENTIATION

The physical layout of the operating Theatre Suite is schematically represented in Figure 11 capturing the route taken by patients.

Physical layout

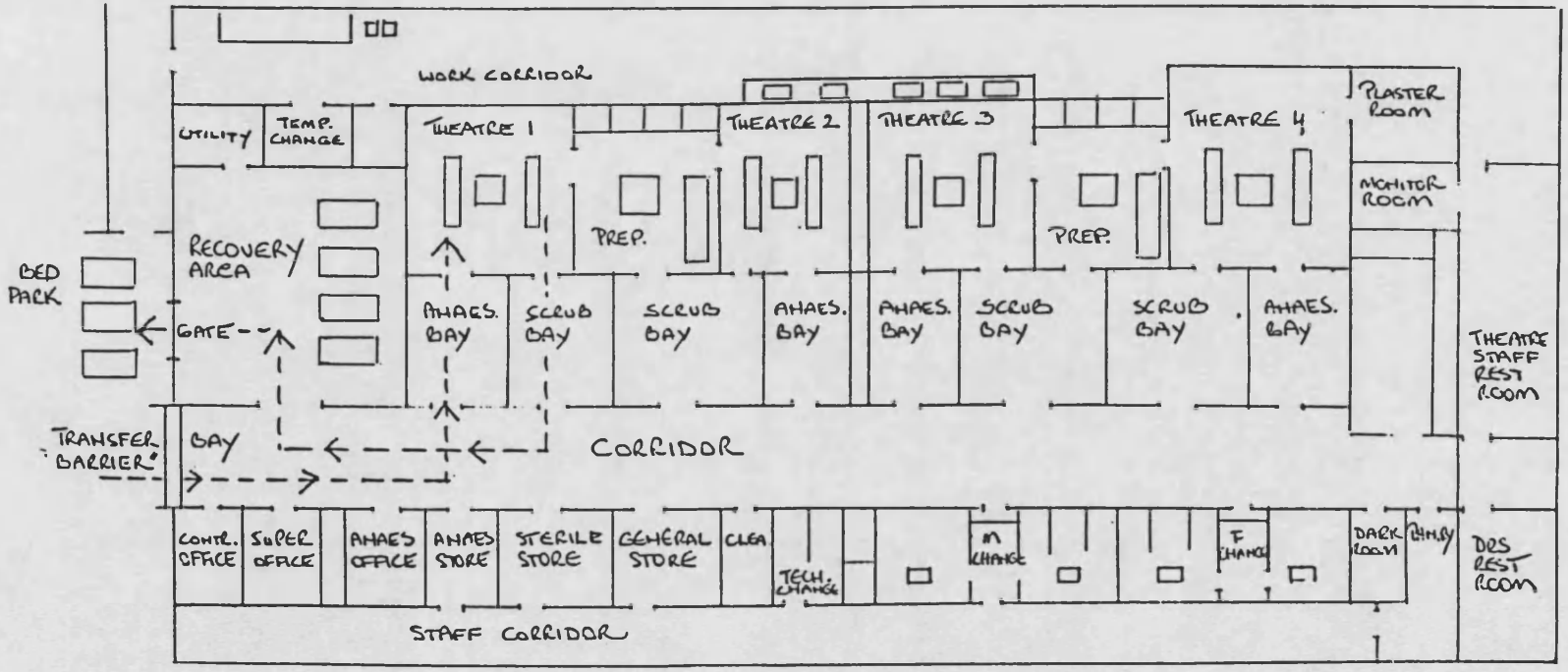
The Theatre Suite at the BBH consists of a suite of rooms which are arranged in such a way that they provide a series of special environments suitable for surgical procedures. The suite of rooms are grouped in one of four zones according to their "degree of cleanliness" as well as the various functional requirements within it. The four zones are: Protective Zone, Clean Zone, Sterile Zone, and Disposal Zone. Personnel and materials are only admitted to the sterile zone after being previously filtered and serviced by the protective and clean zones.

Protective Zone. This zone contains, first of all, the reception desk or control office which looks out at the transfer bay leading into the main transit corridor for patients and the staff corridor. The control office is virtually a control station for the checking of all personnel, including patients, who enter from the "unrestricted zone" of the Hospital in general. A gate or "barrier" divides the transfer bay from the main corridor which acts as the physical boundary for the various inputs into the sub-system.

All personnel who may enter the operating theatre prior to or during an operation must first of all pass through the changing rooms. The latter are adjacent to the staff corridor and are mainly used by the staff associated with the actual operating theatre. There are three change rooms catering for the male medical staff, the nursing staff (which is also shared by female medical staff and visitors), and the technicians, porters and male visitors.

Figure 11. Physical layout of the Operating Theatre Suite.

Arrows indicate the route taken by the patient.



Apart from the control office, other ancillary service rooms are the offices for the Supervisor of the Suite and the Director of Anaesthesia; the dark room for radiographic and photographic use; the monitor room used in conjunction with major surgery containing equipment which measures and records information about the patient's condition during the operation; the plaster room; the store rooms; and right at the back, two separate rest rooms, one for the medical staff and one for the rest of the theatre staff. This backstage area (Goffman, 1978) serves as a temporary retreat for staff to relax and unwind between operations. The atmosphere here is quite different.

The post-operative recovery area is also located in the protective zone where it is used solely for the recovery from anaesthesia. Services to this area include a kitchenette, utility room, nurses station, and preparation space for setting up trolleys. Bed bays are also provided with connection points for different types of equipment. It is from here that the patient is sent back again into the outside world of the Hospital.

Clean Zone. This is the service-territory consisting of the anaesthetic and the scrub-up bays. The anaesthetic bay contains the appropriate equipment used by the anaesthetist when he begins to administer the anaesthetic. The scrub-up bay is used for staff to wash according to strict regulations. Each theatre is thus serviced through the use of an anaesthetic and a scrub-up room. Both of these rooms are located between the theatre and the main corridor, thereby providing easy access to the sterile zone and to the protective zone.

Sterile Zone. The highest degree of cleanliness is found in this zone which contains the four operating theatres and two preparation rooms, each servicing two theatres as wella s separating them from each other. The preparation rooms are used for the lay-up of packs of sterile instruments ready for issue to

theatre prior to surgery. The four operating theatres are all well lit and ventilated clean rooms containing the appropriate equipment which varies as to complexity depending on the type of operation. All surgical procedures are carried out in the confines of the theatre. Theatre 4 is the largest room of all and used only for orthopaedic surgery. The rest of the theatres are the same in size with Theatre 1 providing the environment for eye and ear, nose, and throat surgery (EYE & ENT) and the remaining two for both general or gynaecological cases.

Disposal Zone. This zone is known as the "work corridor" and is used for receiving used instruments, soiled linen, swabs and dressings from the operating theatres.

Procedure

The BBH caters for both public as well as private patients needing surgery. The public patient goes to the Outpatient's Clinic and if assessed needing surgery is then booked in. The private patient consults his genral practitioner who refers him or her to the surgeon's private rooms for assessment and the same procedure applies.

The patients and the type of operations vary signficantly in the Theatre Suite. Examples could be a complicated hip replacement for an elderly pensioner; an extremely delicate ear operation on a child; or a caesarian operation involving twins (normal deliveries are carried out in Stanistreet House, the maternity wing).

Pre-operative Phase. Even before the patient arrives in the Theatre Suite, several arrangements have been made in the ward to ensure that he or she is ready for entry and that the proper pre-operative treatment has been given. For example, patients are examined by the surgeon; the anaesthetist determines as to what sort of anaesthetic, if any, to use the next day; the sister

checks as to pre-medication, shaving, the wearing of appropriate attire, and the correct physical identification and labelling of the patient and the operation. This identification procedure is then carried through by the porters and the nursing and medical staff in the Suite. Proper preparation of the patient in this way demands close co-ordination between the Suite and the nursing units.

When the patient is ready, he or she is taken, on a trolley, to the Suite by the porter, always accompanied by a junior nurse, and waits in the holding area to go into the anaesthetic room. All patients sent to theatre are accompanied by their proper medical documents. After having been "rolled over the barrier" onto a clean theatre trolley and a check made as to identity, signature on consent form and other documents, the patient is wheeled into the anaesthetic room. Here the anaesthetist administers the anaesthetic to prepare the patient for theatre. He is the patient's close companion who provides him or her with much needed comfort and reassurance.

Operative Phase. The operating theatre seems to be one of the most intensive technological area in the BBH. It is here that all the surgical procedures are carried out in the confines of the theatre; and it is here that the physiological and social climax is reached. Nowhere else in the Hospital is there the same concentration of highly skilled professionals requiring efficient organizational back-up. The various tasks are closely integrated requiring teamwork and co-operation. This, according to Thompson (1967) reflects a reciprocal type of interdependency where a variety of techniques and processes are used to transform the "human material". Co-ordination is achieved through mutual adjustment or, perhaps even more so, through standardized work processes on the bases of skills and knowledge (Mintzberg, 1979).

Post-Operative Phase. This is the recovery stage following surgery when the patient is wheeled via the scrub room to the holding area and from there to the nursing unit whence he or she came from. (This is providing nothing serious goes wrong and he or she doesn't need intensive care.) The recovery area provides for the careful supervision of the patient's recovery from anaesthesia. This is until such time as the anaesthetist or the recovery room nurse determines that the patient has all his or her reflexes back and is not in a vulnerable state when removed back to the nursing unit. Once there, the patient continues to be monitored for a few hours.

The three major phases define the linkages between the various functions and tasks to be performed. The work flows clearly from one task area to another. If we take the concepts of dependency and power into consideration, then in a sequential interdependency, the preceding tasks can be very powerful over the succeeding one. For example, in this case the pre-operative phase is of utmost importance if the operation is to be successful.

It is the centrality of task and the fact that the whole place is about cutting which is the essence of the theatre. The surgeon has the power because he carries out the essential task in which the other theatre staff support him. Although the anaesthetist has the power to stop the operation, he is still in support - vital but not essential.

Sessions and time

In the Theatre Suite, several operations are carried out at the same time, right around he clock. Consequently there is another focus on the question of time differentiation, namely the way in which these operations are grouped into operating sessions. Staff teams are composed for each session. I noted earlier that Suite as a whole has a task boundary which is unambigous, and that

this did not coincide with a coherent task group. In the operating theatre session there is such a coincidence.

As Trist et al. (1963) and Miller and Rice (1967) point out, this is a condition for high performance, further reinforced if the boundary coincides with a group to which members feel attached. Groups do not necessarily need to be permanent. Changing membership can be absorbed without detriment to performance if roles are clearly defined and supported by appropriate training so that each member can trust the perfomance of the others, and if an attachment is felt to a wider grouping. Such changing membership is common in international airline crews (Miller and Rice, 1967). However, every time there is a disturbance to the coincident boundaries, there is a hazard and a need for management.

In the Theatre Suite, the "team in the session" is the principal operational unit in its work. There are two hazards arising from the structure. One is the composition of the teams, which are not necessarily stable within a session. Although there is a clear and strong attachment to the Suite, the different staff groups have their separate loyalties and staff scheduling arrangements. The second hazard is the ambiguity of the session time boundary. The timing of a session is uncertain, because of variations in the duration of individual operations due to differences between patients and between surgeons, and because of variations in the number of operations in a session. Emergencies and non-routine occurences cannot be scheduled in advance, by definition, though planning can allow for contingencies. There is no agreed arrangement for managing these uncertain boundaries. There is thus a possiblity of conflict arising from a weakness in the structure.

THE SOCIAL ORGANIZATION

Anyone studying such an important and fascinating place as an Operating Theatre Suite and perhaps hoping to institute some changes to its functioning, needs to gain an understanding of its unique culture. As I mentioned in Chapter 2, this means asking questions about the primary task, the technology and the kinds of people handling it, the structure and the roles, and the layout. In addition, we have to look at the atmosphere, the customs, the personalities that dominate the scene, the way people organize their affairs with each other, the way power is distributed, and the manner in which conflict is handled within the system.

We have already mentioned many of these aspects but more has to be said in order to get an appreciation of this unique sub-culture within the Hospital, especially the Operating Theatres themselves which form the hub of the Suite.

Drama, intensity and importance

According to Burling et al (1956) and Goffman (1969) the Operating Theatre Suite is dramatic as well as anxiety and tension prone, because what is being done in there is dangerous and vital. As we indicated before, everything in the system revolves around the patient or "object". It is the patient who is the most important actor on the stage. The fact that the surgeon has the power to enter and change the body (the basic part of the person's security), imposes immense responsibility as well as creating an atmosphere of awe. This is especially so if there is a race against time to save the patient.

One of the surgeons explained:

"Sometimes when we haven't been able to diagnose pre-operatively as to what is wrong I have no choice but to get in there and have a look around. If I see something malignant it's only natural that I wield the

knife and chop out this nasty foreign material. The greater the material the longer the operation and the greater the insult on the person. But let's face it it's all for his own benefit in the long run."

Although operations vary as to their complexity and critical nature, there is always some degree of tension. When the latter becomes very strong, some surgeons have the tendency to flare up or become extremely irritable. Just recently, a theatre nurse commented that one of the surgeons threw an instrument on the floor that was handed to him by the scrub nurse shouting full of rage about her incompetence. Very often the tension eases quite considerably during which time the staff relax more indicated by joking and chatting. The atmosphere is also influenced by the various personalities involved.

It must be added, however, that the emphasis on drama and intensity in the Theatre Suite, varies with the seriousness of the operation. The more difficult the surgery, as a rule, the more personnel are used, the greater number of instruments are required, and the longer it takes. Moreover, with less difficult cases, the tension in the theatre is lower and the atmosphere much more relaxed. It is also less demanding on the staff, particularly the specialists, both physically and psychologically.

Patients

Patients are the principal actors in the Theatre Suite setting, around whom the various activities and interactions revolve. The psychological reactions of patients to their illness and treatment seem to have important consequences for their medical condition. Dumas et al (1965:18) makes the point that

> "a patient entering the operating room for a major surgical procedure very likely is embarking on one of the most isgnificant and potentially threatening experiences in his life. His chances for an uneventful

> convalescence and full restoration of health are influenced greatly by the adequacy of his pre-operative care."

What this implies is that the right social and psychological environment of patients is essential for effective surgery. Many surgeons are preoccupied with the purely mechanical or physical aspects of the patient's problems. This is not only because of their training but because they have little time to spend with the patient pre-operatively. It falls to the charge nurse in the ward to try and alleviate any anxiety and uncertainty that the patient may have. She may try and relieve the psychological stress herself or assist in getting it from someone else like a social worker or chaplain. Albrecht et al (1978) have shown that anaesthetists can have a very powerful effect on their patients. Talking out anxieties and understanding the source of anxiety helps patients to reduce post-operative pain and depression.

"Hospitals are institutions cradled in anxiety" (Revans, 1976:52) and there is no doubt that anxiety and uncertainty are present prior to surgery. A senior nurse in the Theatre Suite reflecting on her own experience during an operation said:

> "I know what strain and anxiety a patient goes through prior to an operation; I've been there myself. I know the outcome, trusted the surgeon and anaesthetist as well as being aware of the procedure. And yet I had this irrational fear and couldn't stop trembling knowing in reality I should be calm and collected and yet .... With all that knowledge I was like that, just imagine someone who hasn't got it."

Wolfer and Davis (1970), assessing surgical patients pre-operative emotional conditions, found that fear and anxiety the night before surgery was for many quite strong. Female patients undergoing gynecological operations, especial

hysterectomies, requested significantly more fear and anxiety than male patients with abdominal complications. The symbolic and practical signficiance for the female role was appraised as very threatening for many women. It was also felt that the rating would have been much higher for male patients but that many would be unwilling to publicly admit fear as well as using the "denial" of anxiety as a coping mechanism.

Studies by Klinzing and Klinzing (1977) and Robertson (1962) also show that operations can be terrifying experiences for children and that special care has to be taken to use the right approach by hospital staff. The Supervisor of the Theatre Suite was adamant that no child was ever left alone in the holding area not only because of the operation that lay ahead but because people with hats and masks are usualy quite frightening for children.

> On the subject of child patients an anaesthetist commented: "Children are treated as something special and we are always extra aware and extra alert about their situation. I always take time for more pre-operative visits so that they can get used to my face and voice. Later, shortly before the operation I can then briefly take off my mask and say - Hello, do you remember me? It's a question of getting down to their level."

Pre-operative care by the Hospital staff not only involves explaining the nature of the operation and the procedure involved, but also orientating oneself to the thinking and feelings of the patient. These may be things that relate to family matters or financial concerns and have very little to do with the operation at hand. In practice there is a tendency to assume knowledge of the patient's point of view.

Team work and co-operation

The intensive technology is linked to the high degree of reciprocal interdependence between the various tasks within a very confined space. Work flows back and forth from one work role to another. Every operation involves team work and therefore co-operation. Each person is dependent on various others with the focal person, the patient, fully dependent on everybody.

Within the Operating Theatre itself, co-ordination is achieved through the standardization of skills and knowledge; that is, virtually without mutual adjustment or direct supervision. By virtue of their training and experience the key players know exactly what to expect of each other. According to one of the anaesthetists:

> "For theatre to function effectively there has to be a good rapport between the surgeon, the anaesthetist, and the nursing staff - it's a team effort. If you take away any one link in the chain then things can become very stormy. The surgeon is really dependent on me because he can't do anything unless he gets my nod that I have the patient under control. Sure there are status differences but once the operation starts, you can't really rate any one above the other. I think that everybody in there is important."

On the same subject, one of the Theatre Nurses commented:

> "For the patient's sake we have to forget our dislikes of this curcial moment. Otherwise this patient suffers even though he's just a piece of furniture lying there. It's a team effort with everybody contributing something. Sure, I get frustrated with the personality conflicts and the high pressure work situation but overall I enjoy my work. It's great to be a member of a team and when the patient is wheeled out and you know its all been successful it gives you a lift and a feeling of accomplishment."

Apart from looking at team work as a whole, examples can be drawn of co-operation in various pairs of team members such as surgeon-anaesthetist; surgeon-assistant surgeon; surgeon-nurse; and senior nurse-student nurse. By doing so, we can sometimes detect conflict between the members which is often only brought to the surface outside of theatre.

Talking about the relations between surgeons and nurses one of the Junior Theatre Nurses angrily said:

> "I get tired of being the scapegoat when something goes wrong with the operation. I know we've been taught to disassociate ourselves of frustrations and anger of surgeons. I regard myself as rather experienced but there are times when I just can't anticipate what's needed and yet get my head blown off by some arrogant and nasty medico who thinks he can walk on water. I just can't ignore that and won't. They depend on us a great deal and if they can't be civilized about it they can go and jump."

Another Registered Nurse added:

> "It's really a thankless task. These surgeons are a particular breed. Their massive egos won't even allow them to acknowledge you let alone treat you politely. Some are very chauvinistic and I'm sick of the victimization that goes on in theatre. But you are left in a no-win situation. It's to nobody's advantage to make trouble because we have to work as a team for the sake of the patient and that means putting aside any feelings that we may have."

However, a different point of view was made by an associate charge nurse:

> "I like to work in theatre because its challenging and rewarding. I'm not one of those people who feels threatened because of an inferiority complex. I've got

no squabbles with the surgeons and appreciate the tension they work under. They are always nice to me and appreciate my help. Of course they get irritable and moody and have their idiosynchrasies. But you accept that and don't take it so seriously. It's a good feeling to be one of the team. I know each one well and I can read their next move and what he requires for the operation. That's what my job satisfaction is all about."

The Team (The cast of characters)

Surgical procedure in the treatment of illness or injury requires team work and co-operation. Staff involved in this procedure must be highly skilled and suitable to the task at hand because what is being done is vital and dangerous.

In order to achieve its primary task, the Theatre Suite is structured so as to integrate human activities around various technologies. That is, the technical system is determined by the task requirements of the Suite and is shaped by the specialization of knowledge and skills required, the type of equipment used, and the layout of facilities. The technology of this major sub-system in the Hospital is the complexity of techiques used in the conversion process, namely the surgical procedure.

It is this technical system which is the prime determinant of the administrative structure of the Suite and the type of staff required; the kind of structure appropriate for task performance. Other factors relating to staffing are the type of surgery undertaken; the number and occupancy percentage of surgical beds, the length of daily operating time and the number of operating days per week.

Taking the example of the Operating Theatre itself, we can list the following key players according to status:

Surgeon (the one who operates).
Anaesthetist (the one who administers the anaesthetic).
Assistant Surgeon (the Registrar/Resident who assists the Surgeon).
Circulating (Scout) Nurse (the one who co-ordinates to see that everything that is required is available).
Scrub Nurse (the one focusing on the table assisting the Surgeon).
Student Nurse (the one who is taught to gain the ability to assist as a team member).
Technician (the one who assists the Anaesthetist).
Porter (the one who takes the a patient to and from the Theatre Suite).
Ward Clerk (administrative fruition).

If we enlarge on the operating theatre and include the whole of the Suite, then obviously the whole nursing administration staff (Supervisor, Charge Nurse, Associate Charge Nurses) as well as all the ancillary nursing and non-nursing personnel must be added to the list. There must be a balance of the experience levels of staff on each shift. It is the responsibility of the Supervisor for determining the staff establishment within the Suite.

We can see how regimented the Theatre Suite really is showing the hierarchy of occupational prestige and power. It indicates the political and social scenario within the Suite.

Expert power

Although the Supervisor holds position power due to her structural position in the Theatre Suite, there is a shift to expert power if the focus is on the Operating Theatre itself which is the key area of the surgical process. The surgeon has the

obligation to direct and manage a particular activity system which is the surgical operation (Goffman, 1969). He is responsible to see that the operation is effectively carried through. He contributes most directly towards achieving the primary task in the Suite and as such is the person in control. Everything else revolves around the accomplishment of that task.

Many support this argument that the surgeon is the one who is unquestionably in charge; others feel that as far as authority is concerned both the Surgeon and the Anaesthetist are equal. Asked about who has control in the theatre, a Surgeon replied:

> Although I see myself as the captain of the ship, I'm really the first amongst equals. We all contribute but without my knowledge the ship would sink. As far as the Anaesthetist is concerned he has quite a role to play, but I'm the decision-maker."

Another Surgeon commented:

> "There is a good relationship between the surgeon and the anaesthetist. They are well trained and are now also highly specialized. We are very dependent on them. However, they are the bridesmaid and not the bride. There isn't that afterglow with them."

To the same question, an Anaesthetist declared:

> "Where the power lies depends on the situation or area. If a decision has to be made where to cut or what instruments to use, its the surgeon's domain; it it's a matter of the patient needing more blood it's my decision. There are two chiefs because we both have the patient's life in our hands although the surgeon has the final responsibility."

A Resident remarked:

> "The Operating Theatre is a tense place because you've got the dramatic question of life and death. Everyone

works as a team although the surgeons think they are the epitomy of God. Some anaesthetists are sick of the surgeons putting them down. The first ten or so minutes and the last are vital. Ultimate power rests with the anaesthetist because he determines whether the surgeon can operate or not."

There is no doubt that the medical specialist dominates the Operating Theatre due to his technical expertise and autonomy, which means he controls the skill necessary to operate. It gives him power to be in control and thus influence the action of the rest of the theatre staff. Expertise is one of the most powerful sources of influence especially in a technical oriented system. The more specialized (horizontally) the task, the more dependent the system becomes on the expert to achieve the goal. In the Theatre Suite, the medical specialist is at the top of a hierarchy of skill or occupational prestige.

We can extend the power base even further by the fact that the surgeon (or anaesthetist) cannot be replaced during the surgical procedure because of his expertise. No one else in the team can be substituted because no one else is capable of performing that vital function.

It is really the surgeon who is ultimately responsible for the outcome in the Operating Theatre. This, together with his expertise and irreplacability, confers authority upon him. However many theatre nurses feel that the Surgeon really depends on the Anaesthetist because the latter has most of the control over the patient. Perhaps all we need to ask is "who leaves the theatre first after an operation?" We know because we already observed such an event at the beginning.

Personalities

To understand the unique culture of the Theatre Suite, and, especially, the operating theatre, we have to be aware of the personality of some of the key actors. There is no doubt that what goes on in the theatre takes its tone and whole atmosphere from the attitudes and personality of the surgeon.

Burling et al (1956) describe the unique quality or feature of each Operating Theatre due to principally the personality of the surgeon, the nurse and the creative course of surgery itself. In the words of a senior theatre nurse:

> "The atmosphere in the operating theatre depends very much on the surgeon, the type of operation, and how many staff are new. In Theatre 1 (Eye and ENT) the atmosphere is very subdued and quiet (total silence at times) because the surgeons themselves are quiet and rather serious. They don't like you talking, let alone joke while operating on such a delicate organ as an eye, for example. In Theatre 4 (Orthopaedic) the mood is usually quite different in that it's far emore chatty and noisy. Mind you, I've seen some of these extroverted, aggressive, and insecure surgeons throw a tantrum and in their rage and temper yell and carry on redirecting the blame on us. With time you learn when to shut up and when to chat as well as trying to put up with all these idiosyncracies. I suppose people change once they walk in here and perform differently because of the stress and the tension they are under. To some extent you learn to accept that."

When asking a Senior Resident whether one can stereotype the personality of a surgeon to, say, that of a physician, the he replied quite knowledgeably:

> "Oh, I really think you can. Judging from those that I've met and talking to colleagues one can paint a reasonably good picture. Surgeons are doers who are

motivated by being able to cure and see results. If a patient is dying they don't want to know because it reflects failure. They feed on success and get their satisfaction from saving lives and limbs. To surgeons things are very much cut and dry, black or white. Most of them are extroverted and can be quite aggressive. Physicians tend to be more introverted, quieter and perhaps more intellectual. They specialize on internal medicine which can't be fixed with an operation. They are more like diagnosticians who work alone and not in teams as surgeons tend to do. That's the way I see them anyway."

A visiting medical officer, not a member of either of these specializations, had this to say:

"Surgeons are far less conservative than physicians. There is an old physicians rule of thumb that if you send a patient to a surgeon you must expect him to operate. They tend to be active in their treatment, and are extroverted, flamboyant and more militant. Most of them think they are superior as far as professionalism is concerned."

The unique sub-culture of the Operating Theatre Suite creates a boundary separating it from the rest of the Hospital conveying a sense of identity for the staff working there. They recognize their status and role as something special; their world is the Suite, much more so than is the Hospital. The stories of villains, gods, and fools persist; descriptions are given of the dramatical events in theatre; and the rituals in the surgical process, the green attire and the status differences between the key actors are all there for us to listen to and observe. It is a mixture that makes the Suite the type of place it is.

CHAPTER 17

THE OPERATING THEATRE SUITE: PRESSURES AND CONFLICT

> "Some of the most important features of organizational life concern power, influence, politics and conflict. They are certainly central to the process of change, yet they are rarely discussed" (Cope, 1981:123).

As the months went by, the general feeling of discontent, hopelessness, and anxiety among the OTS staff surfaced more and more. There is now a great deal of concern right across the spectrum. Due to the recommendation of the Joint Consultative Committee (Joint Consultative Committee Minutes 8/12/87), the Board of Management decided to place the current OTSC in recess for six months and replace it with an Interim Committee to operate for six months. It was hoped that this new body could delve more deeply into the issues and problems within the Theatre Suite and hopefully come up with some concrete solutions.

The new Committee was set up, comprising two members from the Board, the Hospital Executive (Chief Executive Officer, Medical Superintendent, Director of Nursing), three members from the medical staff, the Operating Theatre Suite Supervisor, and a member of the theatre nursing staff. Prior to the setting up of this Committee I was approached by the CEO (with the approval of the Chairman of the Board) as to my recommendation concerning the Committee structure. In addition, because of my research and the emphasis of the thesis on the phenomenon of conflict, I was asked whether I would be willing to represent the Board, together with the Chairman. I agreed hoping that I could contribute, mainly on a consultative basis, to find a way so that the conflicts within that unique sub-culture could be effectively managed.

I then began to reflect on the time spent in the Theatre Suite, observing, interviewing, and scanning through minutes and other documents. It was time to pinpoint the numerous frictions and problems facing this department. It seemed to be all there - the non-adherence to protocol; the various personality clashes; interprofessional friction; factional dogfights; the need for more staff; and committees that don't function effectively. Everywhere along the line there seems to be a breakdown in communication. Accusations flow back and forward between Medical Staff and Nursing Staff, that the other party is not interested in listening or reading what has been decided. Or simply, that information is just not being forwarded onto the people concerned, neither formally nor informally.

The way that I am going to present this chapter is to begin by discussing the conflict which surround the role of the Superviser, followed by discussion of conflicts arising around other people and in various factional skirmishes. Finally, I shall deal with conflicts arising over the management of time boundaries and resources.

CONFLICT SURROUNDING THE ROLE OF THE SUPERVISER

A presenting symptom

Over the years the Operating Theatre Suite, like any other organization or department established its own unique culture. The previous Supervisor (who retired two years before I began the research) had been in that position for many years and was highly respected and liked by both medical staff and theatre staff. Although the operating theatres themselves are run very much on a patriarchical basis, the nursing division within the Suite was accustomed to a mother figure who hovered over her children and protected them. It seemed somewhat too cosy.

Nevertheless, the matriarch was democratic in her approach to decision-making, being able to reach a compromise wherever possible. Moreover, she also saw the need for certain change, especially the matter of overbooking of theatre lists, though as her retirement approached she did little to push for changes.

> "Peoples' ideas about the past are an intrinsic part of the contemporary situation and affect social relationships" (Sofer, 1972:357).

Old habits are indeed hard to break, because they are closely linked to tradition. It's the way that everyone in the Theatre Suite has always done things and expect to continue to do so - "the good old days". Change is resisted because it strikes at the culture of the unit. Conflict is inevitable in the process.

When questioned about the personality of the previous Supervisor one of the visiting medical staff commented:

> "I must say that I and most of my colleagues in theatre had a great respect for the old Supervisor. She was never really buddy buddy with us and there were often real stand up rows over certain issues, but we always got a hearing and a compromise could be reached, say, taking a case over lunch time because it suited me. At

other times, however, she would put her foot down. But it seemed flexible all round. She once said with a smile that success in theatre with the medical staff revolves around making them believe that they get what they want but it's me who institutes.

She was also marvellous with her staff of girls. She could literally read their moods and place them where it would bring out the best in them. She would pair some girls with certain surgeons where she knew that the partnership would be more harmonious which in turn created a better atmosphere in the theatre to the benefit of the patient. Her empathy towards situations and people was marvellous; she's a big loss to this place."

This view had also been expressed by other older medical and nursing staff working in the theatre at that time. However, in fairness to the present incumbent I recognise that it is always difficult to take over from someone who had been at the helm for so many years. Staff get accustomed to a leader's style and personal make-up as well as arrangements and methods of work. What is happening has been called the 'Rebecca syndrome' after Daphne du Maurier's novel of the same name in which the new wife is adversely compared with the memory of the dead wife. Adverse criticisms are being made by the surgeons of the new Superviser. Everything that she does is negatively compared with what happened with the previous incumbent.

The criticism directed at the new Supervisor focuses mainly on her personality and approach to issues. One of the surgeons:

"The new Supervisor is causing me a great deal of heartache. Her militant, abrasive, obstructive, and inflexible approach coupled with poor communcation skills is making things for everyone here extremely difficult. She has a complete lack of finesse and

diplomacy saying the wrong things to the wrong people and then backs off, but the damage has already been done. She seems to have the knack of rubbing each and everyone of us up the wrong way; instead of defusing a situation she inflames it. The atmosphere is so completely different at Mt. Alvernia. I take as many patients there now as I can. It's a joy to come to theatre there whereas here I get uptight even before I lay eyes on the patient, and that's really saying something. The fault lies with the Supervisor and not the system."

According to one of the theatre sisters:
"We are so fed up with the whole situation, no one can relax with her, she goes right of the handle. Her whole manner is so demeaning and antagonizing; the sort of hands on hips look at me attitude. So many experienced and efficient senior girls have already gone from here; it's a great pity. And yet she always seems to support the newcomers. Perhaps they have similar ideas or she doesn't seem to feel so threatened by them."

A technician had this to say:
"At times you feel like throwing the towel in. You get tired of being lectured at and picked on all the time. We are treated like children."

The response from a doctor not involved with the Suite was:
"You know I have some sympathy with the new Supervisor because some of these surgeons can be quite pompous and hysterical. But, then again a good Supervisor should even be able to handle those personalities like the previous one could. She can't even handle the placid and nice ones without them getting annoyed and uptight."

Yet in her defence of the Supervisor the Director of Nursing replied that:

> "The new Supervisor has had a great deal of experience and she is a very capable girl. Sure, her manner is somewhat abrasive, but she is extremely knowledgeable, well qualified and has great ability. It's time these surgeons stopped ruling the roost and were also more cost conscious as far as equipment is concerned as well as being more considerate when it comes to scheduling operations at their own convenience. Our girls have enough to cope with as it is."

An analysis

The newcomer is seen by others to be the cause of all the contention. The symptom is the 'clinical rejection' of her by the medical staff, as if she were a piece of foreign tissue. "The fault lies with the Supervisor, not the system." However is seems to me that it is more a question of her showing up the faults in the system.

It may well be that the Supervisor's personality tends to rub people up the wrong way: however there are other issues at stake. Firstly, the Superviser is an extended arm of the Director of Nursing, who has made it quite clear to everybody that she is fully behind the Superviser in whatever changes need to be made in the Theatre Suite. She is acting as a scapegoat, attracting from the medical staff their dislike and contempt for the Director of Nursing, which opens up one way for them to get back at her.

Secondly, the Supervisor is being rejected because of her role as change agent. The Supervisor is determined to evolve her own ideas, policies and procedures for the system. She feels that as an administrator of the unit it is her reponsibility and right to do so. However, there are various factors at play which make the introduction of change frought with difficulties and trauma.

According to Sofer (1972), tensions between functional departments become especially noticeable when change is proposed or introduced in work arrangements. Adding to her difficulties is her lack of power, the gender issues, and as I already indicated earlier the fact that the doctors are thinking individually and not thinking organizationally.

The doctors have always enjoyed an authoritative role in their relations with the nursing staff. They are united in their opposition against what they perceive are potentially threatening changes by the new Supervisor. They are concerned about the lowering of the efficiency and standards of the Theatre Suite.

The way the Supervisor plays her role affects her strategic position, and the reactions of medical staff. One reason that they dislike her is that they do not like a woman who stands up and challenges their rights to have things organized their way. Because she is as she is, there is another score being settled by the doctors. The slanging that the Supervisor gets from those around her is also partly due to what seems to the others to be her lack of empathy and leadership skill. I must admit that I also partly go along with this perception.

Although the Supervisor possesses technical skill, her understanding of the culture in which she operates is limited. She is technically and individually oriented, as are the medical staff. Her style is that of combating, confronting and forcing the issues instead of the more smoothing approach of her predecessor. She is fighting a battle for causes she genuinely believes in. It may be true that production of conflict is an inevitable part of effecting changes since the old ways had to be challenged. It may be true that from this point of view there was too little conflict in the previous situation (cosy). The amount of conflict which her actions have made manifest is more than is compatible with the sort of continual compromises needed to keep the work going.

It is a power struggle where both parties are competing or standing up for their rights in order to protect their self-image from what they perceive as illegitimate influence. Because this type of strategy does not bring about agreement, the conflict remains unresolved, leaving bitter resentment and frustration along with efforts to retaliate.

The situation requires negotiated contractual arrangements between the Supervisor and the doctors, which are made difficult by the multiple sources of the confict.

As the discussion of the Suite proceeds, the more it will appear that the attention paid to the superviser is disguising other serious difficulties.

CONFLICTS SURROUNDING OTHER ROLES

The surgeons

The practitioners in the Suite see the causes of conflict as largely rational involving decisions over who should manage the patient. That is, who should have mastery over the situation. Traditionally, they have control over most facets of the Theatre Suite activity and strive to exercise this authority for the welfare of the patient (as they see it) coupled with their own financial benefit.

Apart from the open warfare with the Supervisor, minor skirmishes also break out between the practitioners and some of the newer, more educated, and skilled nursing staff. The difficulty with the service in theatre is compounded by the fact that the practitioners are visiting but also spend but a small part of their working week actually in the Theatre Suite (not like the surgeries and clinics) and yet expect absolute authority and even subservience from the staff who, at the same time, have a strong desire to extend their authority. This is simply not tolerated by the medical staff who see nurses as facilitators and not interfering with their practice autonomy. As one surgeon succinctly put it:

> "The surgeon is in charge in the operating theatre as he has the ultimate responsibility for the life and welfare of the patient. It is the duty of everyone else in the operating theatre to do all in their power to assist him in his task and to minimize tensions of any kind. There is no place for arguments or acrimony or hostility here.".

Even between the surgeons themselves there seems to be a lack of co-operation and effective communication. This is partly due to the fact, as we indicate before, that all of the medical staff are extremely busy, have interests also outside of the Hospital, but are also very much oriented towards their own specialty. This

also influences their perception, thereby interpreting problems from their own point of view and not necessarily from that of the Medical Division as a whole. Some senior nurses are also of the opinion that even the surgeons are split into two camps, those representing the "WASPS" who are regarded as the Old Guard and come from England (and Ireland), and the New Guard from India, Sri Lanka and China.

> A professional from outside of the Hospital explained that: "Most of my friends are doctors, either Surgeons or General Practitioners and as far as I can determine there is definitely that under current of resentment against the foreigners from the white doctors. Most of them are good doctors but because they've got their intellectual and cultural roots in the U.K., the old colonialism attitude still lurks in there. It's a very subtle element but it's there nevertheless."

The anaesthetists.

Intra-group conflict is also noticeable between two sub-groups within the anaesthetist camp, namely the "A Team" and the "B Team". The former consists of older members including the head of the department and the other is made up of younger personnel some of which are regarded as very keen and enthusiastic. According to a Registrar:

> "They are like a bunch of little boys playing war games. They call the A Team the "Tom and Terry Show" and if the B team make a mistake then these older fellows gloat and are reluctant to help them out. They (the A Team) can be very arrogant, bad mannered and condescending to Resident Medical Staff. Some of the Registered Nurses are pro A Team and if anyone thinks otherwise they are left out."

The views from the B Team seem to suggest that things have improved when one of the anaesthetists commented:

"Sure we have our differences now and then but things are running a little smoother now. There is none of the toing and froing. We now have regular meetings, minutes are kept and the Director (of Anaesthesia) is now the spokesman for our department. I'm quite happy with the way our department is now run."

The technicians.

One other obvious inter-group conflict is that between the technicians (paramedical staff) and nursing staff. Some senior theatre nurses regard the technicians as lazy and over-sensitive who seem to lack the interest and the will to contribute. Often equipment hasn't been restocked and some are out the door even before their shift ends. Some of the anaesthetists support this view adding that things seem to have got worse in the last twelve months. However, everyone is dependent on them and so the friction continues.

The theatre technicians, on the other hand, complain about last minute changes to the work roster without adequate warning and being moved from one theatre to the next at the whim of the Supervisor. Another complaint centres around the fact that everybody regards them as a minority group with no status or right of appeal and that they are required not to do jobs which they have done for many years.

As one technician bitterly complained:

"Although I get some satisfaction in helping patients, my biggest frustration is the way we are treated by the Supervisor and her staff. They don't accept or respect us, especially the new ones from Melbourne who are envious because we get on with the Surgeons and Anaesthetists. Those youngsters have no experience and

are put in charge of the older nursing staff who have far more nous than they will ever have. Pieces of paper seem to count for everything these days. I wish we were back under the old system (old Supervisor) when there was no pressure or tension."

The difficulty revolves around the fact that the technicians are administratively controlled by the Director of Nursing and organized by the Superintendent. In theatre the Charge Nurse takes control but during the operation they are responsible to the anaesthetist.

CONFLICT OVER THE MANAGEMENT OF BOUNDARIES

Another major source of conflict in the Operating Theatre Suite is the management of time boundaries which occur between individual operations and between operating sessions.

Theatre lists.

One of the many functions of the Supervisor is the important task of finalizing the daily list for elective (pre-booked) surgery sessions drawn up by the various surgeons. This task needs some further elaboration as it has become an area of upheaval and contention on the part of the medical staff and other key players associated with the Suite.

The only hospitals in the region with major operating theatres are the BBH and Mt. Alvernia. Surgeons and anaesthetists rotate from one institution to the other serving both private and public patients at the BBH and private patients at Mt. Alvernia. Each hospital carries a list on a weekly basis which is held by the Theatre Suite, the Admissions Office and the wards, indicating the various session times so that the visiting medical staff can attend on a regular basis.

Patients for elective surgery (separate lists for private and public) are entered on the list and booked in by the surgeon two days in advance. Maximum length of sessions is three and a half hours from 8.30 to 17.30 hours with various breaks in between. In addition, emergency cases are taken in and semi-emergency operations are added if there is room available and certain conditions apply. The Theatre Suite is open for 24 hours with nursing staff on the premises and visiting medical staff on call for emergencies.

The Supervisor monitors the sessions so that the surgeons do not over-book and also start and finish within the allocated time. The pressure on the rostering system is enormous because each

session must be adequately covered with the proper of nursing staff to patient. Moreover, the Supervisor must also make sure that the sessions and the staff hours complement each other. Other problems facing the unit administrator regarding the theatre list, are, amongst other things, last minute additions to the list, out of hours operating, Theatre Suite attire, proper asepsis procedure, and the slowing down of sessions due to student nurses' teaching requirements.

Waiting time.

I have mentioned earlier the increase in waiting time for public patients awaiting surgery. This increase is due to the following factors: people opting out of private health insurance; union regulations regarding the number of trained nursing staff to number of patients on wards; ageing populating; closure of smaller hospitals who were able to perform minor surgery; beds being closed due to lack of funds to employ staff; the complexity of the operative treatment increasing operating time; lack of skilled operating room staff will ing to work in country hospitals; and the amount of emergency cases cutting into the elective sessions. There is also the opinion that some surgeons have a greater throughput of private patients compared to public patients because for the former they are paid on a "fee for service" basis which is at a higher rate than on a "sessional basis" relating to public patients.

The visiting medical staff can also add strain and conflict to the situation by scheduling operations at their own convenience which in the past meant working a large number of list hours after the scheduled closing time at 17.30. The additions of unscheduled patients to the list, overbooking, irregular starting and finishing times, and the slowing down of sessions because of teaching requirements of student nurses are all causing disruptions to the work schedule and the smooth running of the Theatre Suite.

Deployment of staff.

All these factors are putting enormous pressure onto the Supervisor who has only a limited number of operating sessions, theatres, and staff available. Her task is to deploy her staff in such a way that the work of the theatres is covered in the most effective way possible and that the staff themselves are not overloaded or duly stressed. This is not easy to achieve in an environment where there is already a shortage of qualified personnel and morale rather low.

Focusing on that task the Supervisor said:

"My role is to see that the lists are appropriate for the day. The surgeons continuously try and overrule you as to the number of operations. I'm keen to control the lists even better. And it has got better; the figures are up so with less staff we are achieving a higher work load, so you can't really say that I'm holding them (the surgeons) back. At the same time my responsibility is also to my staff. I'm making darn sure that they are getting fed and watered and have rests and meal breaks."

The Director of Nursing is also very concerned about the manipulation of the theatre lists, saying:

"The sessions are running overtime because the doctors want to do as much surgery as possible in their individual session. They are putting one more cases than are allotted and then don't even turn up on time and still expect my nurses to be there. The whole thing is so unprofessional."

To this situation, one of the surgeons replied:

"The operating theatres are not utilized enough considering they are one of the most expensive departments to run. With all this working to rule attitude and demarcation demands, the volume of throughput is less because the number of operations

have been reduced. The whole situation is ludicrous and unacceptable."

An anaesthetist added:
"I don't mind staff having lunch and tea breaks but the way times are staggered now is rediculous. They are going to extreme, leaving absolutely no room for flexibility. I had to leave for an hour and come back the other day instead of being able to carry on with my last case just because someone had to have a tea break. This frustrates everybody including the nursing staff. This stubborn and inflexible attitude is hard to wear."

CONFLICT OVER SUPPLIES AND COSTS

Equipment, supplies and theatre attire.

Other aspects of contention are the purchasing and use of equipment and the wearing of operating theatre attire. Some surgeons are apparently requesting the purchase of needed equipment only to find that their requests are repeatedly denied. Nursing administration, on the other lying around which is not really being used. Besides, there is sometimes disagreement amongst the visiting medical staff themselves as to what equipment should be purchased.

One of the problems relating to medical and surgical supplies that is coming to a head, is the cost being incurred due to the high price of overseas purchases. The Pharmacist is responsible for the purchase of these items and try to keep them within the allocated budget which in turn is the responsibility of the Supervisor. Yet, the medical staff can order according to their own preference and needs. At the moment, the items being purchased are over-budget and a revision of the system is necessary.

Although the Pharmacist is accountable for the purchase he has no control over its use which is leading to conflict. As the pharmacist angrily remarked on this issue:

> "I have one of these surgeons at the moment who is insisting on using certain internal hip replacements and won't budge. These particular items are very expensive and I'm already 18% over budget. Hell, there is no way I can say no or you can't have it. They run the show. We definitely need a committee to review the whole matter."

The Supervisor feels that the present policy on OT attire is not being adhered to and that this should be policed much better, although she seems sympathetic to other aspects such as the

wearing of rings. However, one of the Surgeons remarked:

> "I know she (the Supervisor) is cost conscious but so many decisions revolve around such petty things as these new caps which we are supposed to wear. We look like a pack of fairies wearing these stupid new coloured hats, apart from the fact they they slip off continuously. We have a continuous battle raging over equipment, hats, etc. There is never any consultation or negotiation about these matters."

This is another instance of a conflict between individual thinking and organizational thinking on the part of the medical staff. The view is that 'this is my patient' as though the doctor and the patient were not part of the Hospital, and that the means with which treatment is effected are unlimited. This is a relatively recent development in medical practice, and not a feature of private practices.

THE INTERIM OPERATING THEATRE COMMITTEE (IOTC)

A new Interim Theatre Committee has been formed in order to look into the problems and conflicts in the Suite. The first meeting was scheduled to be held on the 29th January 1989. The members of the Committee were the members of the Theatre Committee, with the addition of the Chairman of the Board and myself.

Phase 1

The inaugural meeting of the Committee took place on Friday, 29th January 1988 (see Appendix 3). Prior to this meeting I had several discussions with the Chief Executive Officer in relation to the situation and he gave his support to my suggestion that the several major factors mentioned in the previous Chapter should be given serious consideration.

The aim of this first meeting was to decide what basic guidelines were to be taken and where the priorities of the investigation should lie. I then gave my own views and feelings about the role of the Committee and put forward a proposal that I would write a report on the situation in the Suite as I saw it.

The idea was to clarify the situation paving the way for a better understanding between the conflicting groups within the Suite. I hoped that this would also provide the ground work on which to introduce change and achieve better management of the Suite. It seemed to me an ideal opportunity to speak quite openly about the issues and the contraints at work, including questions of morale, cooperation and other factors which might surface. The Committee agreed to meet in a fortnight to consider the report.

Having completed the first round of discussions, I wrote my report using an approach and ideas based on the writings of Sofer 1961, Rubin and Beckhard, 1972, and Cope, 1981 (Appendix 1).

Phase 2

The second meeting of the Committee was held on the 12th of February 1988 and having circulated my report to the members prior to the meeting I was then asked to describe the situation as I saw it outlining the importance of the Theatre Suite and the various pressures and problems. The information on the Supervisor had to be treated rather delicately as this became a rather sensitive issue. In addition, I pointed out the need to see the connection between what people in the Suite were doing (the primary tasks) and to reflect on how they were going about it (the internal group process). I suggested six key factors which I felt affected the functioning of the unit and which should be carefully analyzed: goal clarity, decision-making process, role expectations, communication patterns, leadership, and the concern for each other's needs.

Having provided the summary of the situation I suggested an action research approach which involved the collection and analysis of data, feedback of that data to the relevant staff, and action planning to improve the situation. I then pointed out the importance of staff becoming involved and committed to the project. This was accepted and supported by the President of the Committee of Management and the Chief Executive Officer as well as the Director of Nursing (the Medical Superintendent had left that very morning due to illness).

In reacting to the discussion, both medical staff members said that they had worked in other operating theatres both within and without Australia where they had encountered the same difficult environments since all theatre to them seemed the same (see the minutes in Appendix 4).

Phase 3

The third meeting of the Committee was held on 25th February, 1988 where the Director of Nursing presented a paper which was prepared based partly on recommendations in my report and additional feedback emanating from discussions with members of the Committee and Operating Room Staff (see Appendix 2).

The following proposals were put forward for improving working relations within the Operating Room Suite:

"1. To more clearly delineate the broader administrative role of the Supervisor and the Clinical co-ordinating role of the Charge Nurse.
2. To establish more distinct and open lines of communication.
3. To provide greater job satisfaction and increased opportunities for staff development for Operating Room Staff.
4. To make provision where ever possible for the allocation of staff with appropriate skills and interest to assist with specific speciality cases.
5. To foster a more cohesive team approach within the Operating Room Suite and provide opportunities for staff involvement in the decision-making process."

It was also agreed at the meeting to reconstitute membership of the Theatre Committee (which was to be reinstated with the dissolving of the Intereim Committee) to provide wider representation of both medical and nursing staff with the Cheid Executive Officer as Chairman. In addition it was decided to review the performance of the Supervisor after a few months and in the interim to reallocate her office outside the Suite for a trial period.

At least this was a beginning to a more positive approach and understanding of the real issues confronting the the Theatre Suite. I was pleased that I was able to provide some guidance and play a part in the process.

Nevertheless, my impression of the reception of my whole action research proposal was that people were willing to listen for a little while out of courtesy before returning to more important matters. Although the Director of Nursing was prepared to take up some of my ideas, no-one was really prepared to face the sources of the conflicts or do something constructive about them. As the Chief Executive Officer said to me shortly before I left for Bath in October 1988, "It is still the same as before, if not worse."

FINAL THOUGHTS ON THE SUITE

The overall result of all this is that the multi-determined conflict in the Theatre Suite is not being managed. The power battles which are occurring are making the handling of it difficult, and are prolonging its existence. Furthermore, the total work of the Suite itself is not being managed effectively. In Chapter 15, we saw that the manager of the Maternity Unit at Trowbridge Hospital was not only managing the work, but was also handling effectively the conflicts which necessarily arose in the course of making changes in practice.

In the Theatre Suite there is no effective, coherent management of the total operation. The best solution one can get under these circumstances is by continual negotiations and tolerable compromises. The result is that the initiatives to make changes can occur only as part of the power play. It is inevitable that conflict would occur with the introduction of changes, which in turn reinforces the power play.

Athough the drama and the team work involved in an operation may feel much the same anywhere, the mix of the problems facing this Hospital are unique and the solutions for this Hospital have to be unique too.

During an operation, where life and death are at stake, and anxiety is raised, the staff cooperate and adjust. That is when conflicts are contained so that they do not damage the work. Yet when the Operating Theatre Suite is 'the patient', the same capacity for coherent management is not being utilized. Again we have an example of the need for organizational thinking.

CONCLUSION

PERSONAL REFLECTIONS

The reader may recall that there were various reasons for my interest in conflict and that this curiosity generated my exploration. My subsequent research was carried out in order to gain greater empirical knowledge and a deeper insight into the realities of this particular phenomenon in question. I hoped that at the end of my research I would have strengthened my professional understanding of hospitals as organizations as well as gaining a greater awareness of conflict within them. This in turn would enable me to approach this subject more effectively and with more confidence not only as an academic but as a board member of the BBH.

I tried to present the study in such a way that the reader can grasp its full richness and its full life. The more I immersed myself into this new culture, the more the initial fragmented pieces of various happenings fell into place.

The framework or model that I used was useful to some extent because it added a more realistic understanding of conflict within a hospital setting. It gave some justice to the reality, but it was mainly my own experiences of live happenings that so vividly illuminated the conflicting territory I was in.

Using qualitative research helped me to organize, develop and enrich the thesis capturing the complexity of the BBH. During my many encounters I often reflected on aspects or themes that I had come across in the literature, but I knew from my past research experience that real understanding and insight comes from experience within actual circumstances or given situations.

But, it is more than that; it is how and what I perceive, and the selections, interpretations and judgments that I make that is important. It is the way I went about my research which has some

bearing on what is written down. I am part of the data which formed the final analysis.

The cost of undertaking all this research has been enormous, not only time-wise but financially, socially, and psychologically. Nevertheless, between periods of great anxiety, frustration and depression there was joy, excitement and a feeling of adventure during this long journey. Above all, the finished product has given me enormous pride and satisfaction, especially when I flip through the pages and find it is all there and it is real and it is alive.

THE CONFLICT ISSUE

Conflict, in the sense of an inner struggle or incompatible behaviour between parties whose interests differ, is indigenous to human behaviour. It is an inevitable and integral part of social and organizational life. When people work together in a complex organization like a hospital, there are numerous sources of conflict. The magnitude of the conflict is tied to the complexity of the organization, the high degree of interdependence and association and the power relations between the various parties.

I am now going to review briefly the nature of the different kinds of conflict that I have found in the BBH together with the various causes inherent in the psychosocial and structural characteristics of this institution. In addition, I shall identify the salient ones, and endeavour to show how these conflicts were managed or not managed, and what effect this had on individuals and the Hospital as a whole.

The review will be made in terms of the model which I developed in Chapter 3, Table 1. My approach to establishing which are the salient immediate antecedents of conflict will be to look again at actual conflicts experienced by individuals.

The whole research experience did not only teach me something about conflict but opened up a huge canvas of underlying personalities, relations and behaviour. It brought to the surface not only people's insecurities, fears and frustrations, but also their hopes, ambitions and aspirations. Clashes and skirmishes were the order of the day as these key players tried to protect, enlarge or establish their individual roles and power bases. I hope that through the experience of the individual the reader will see the forces at work which influence the conflicts. After all, it is through the individual that I as a researcher was able to gain entry into the complex system of the Hospital.

THE CONFLICTED INDIVIDUAL

Intrapersonal conflict relates to discord within an individual and is seen as a struggle among differing or incompatible values, beliefs, choices, allegiances or demands. The intensity of the conflict depends on the degree of pressure and the individual's ability to cope with and handle that pressure.

Many of the medical staff and the nursing staff have been faced with an ethical dilemma from time to time when the requirements of the role violate the values that they hold. The impact of contextual features, namely industrial relations issues, was apparent in the nursing strike of 1986, for example, which witnessed industrial conflict of unprecedented levels. It was caused by a need for better wages, improvements in staff numbers and higher status in the job. It became a tale of anxiety and torn loyalties for many nurses in the Hospital, including those in senior position on the wards.

Although some degree of stress was evident, most of the senior ward staff resolved the conflict by deciding one way or another on the basis of their perceived commitment. Most of the nursing administration staff and some of the charge nurses remained behind either because of administrative duties or concern for the patients or simply because they did not support the strike. Many of the charge nurses walked out knowing that someone else was taking over their role. Some of the conflict within the Nursing Division today still stems from an air of resentment towards those who didn't support the militant action.

Another intrapersonal conflict is one existing between the individual's own ethical beliefs and the requirements of the position. For example, as we indicated previously, the career path in nursing is via the administrative ladder and not on the basis of clinical expertise which means giving up one's

professional skills. While this allows the charge nurses at the BBH greater status it reduces the contact with patients. That is, the bureaucratic demands of the charge nurse's position is in conflict with the adherence to professional values about nursing care. It's a question of relinquishing the caring role and becoming more bureauoratized.

Although some senior nurses on the wards have become somewhat disillusioned and despairing, most seem to be willing to accommodate to this situation. Nevertheless, the effect in the BBH has been that this adds to a further division between those nurses in administration and those in the clinical field at the coal face - an opening up of orientation differences. In addition, it means that the charge nurses are now less accountable to the medical staff who see this as a threat to their power base and their authority in the management of the patient. This perception is not simply personal in each case, but is linked to the professinalism of the medical staff.

The Chief Executive Officer at the BBH is in a boundary spanning position acting as an agent to the Board, the community and the consumer as well as representing the interests of the Hospital staff to the Government and coordinating them with the demands of the Government. Because of the tight financial control that the latter holds over the functioning of the Hospital, the Chief Exective Officer can only more or less follow an accommodating path to solving the conflict. His relation with the Executive means playing the role of coordinator and mediator. This means reaching a compromise between the conflicting goals and interests of the competing parties by balancing their demands with varying degrees of success. It is a team effort and conflict is avoided through effective negotiation and collaboration.

The visiting medical staff at the BBH find themselves in the role of independent practitioners as well as their institutional role as participating members of the Hospital bureaucracy. They

function as agents for their individual patients, their speciality and profession, the Hospital, and the community at large. Although the obligations of the practitioner to these parties may come into conflict, this does not seem to be the case very often. In fact, most of the medical staff see their medical practice as top priority and use the Hospital more as a work shop and do not get administratively involved. They so not have the time to do so nor do they regard it as acting professionally in the true sense.

Senior nurses on the wards and paramedical staff of the BBH also frequently bear the brunt of the conflict which exists between the administrative demands of the Hospital and the therapeutic demands of the visiting medical staff. When these two parties are in conflict, it falls to the charge nurse to mediate between them. At the BBH some of the charge nurses use their communication skill, diplomacy and fact to overcome the conflict. Others are highly dictated to by the medical staff who use a forcing approach to the situation.

In addition, the charge nurses are frequently engaged in conflict as a result of their pivotal position on the ward and their leader-mediator-coordinator role with respect to other health care personnel. The conflict is often reflected in a three sided attack (or even four sided if we include the patient), of orders or expectations by the medical staff, the bureaucracy and the paramedical staff. The specialists come into the ward and interact together about a common task, creating an interface between each system which has to be managed. Thus there are boundaries in activities which create conflict. In such situations conflict is often solved through collaboration, negotiation and influence or reaching some sort of compromise. A great deal depends on the authority, power and personality of the charge nurse. This varies quite considerably at the BBH due to the marked difference in personalities and communication skills of the incumbents.

Individuals also have perceived roles and expectations based on their values and perceptions about themselves. If there is a disparity between one's values, capabilities and needs and role requirement, then person-role conflict is created. Midwives at the BBH, for example, often find themselves in a role conflict situation where they are placed in a bind. Their clinical diagnostic skills and knowledge are under-utilized when it comes to normal birthing. They know and can feel what another woman's care should be and yet are expected by the obstetricians to play a subservient role which undermines their ability. Some midwives reduce the conflict by accommodating, fully agreeing with the practitioner's orders, or by their skill of gentle persuasion. Whatever choice is made there is always that continuing undercurrent of resentment, frustration and dissatisfaction against the medical party due to the feeling of an attack against one's self esteem and thus the conflict remains.

By these few examples, we can become aware of the complex nature of conflict and its multi-determined nature. For instance, the nurses strike, an instance of one of the contextual features mentioned, still produces bitterness not only between nurses themselves, but between them and the medical staff. The Chief Executive Officer's continual battle with the Government over funding is affected by the intergroup competition for scarce resources. The dual roles of the medical staff and the variable commitment to the Hospital connect with the role conflicts experienced by charge nurses, which in turn are complicated by the complexity of the overall management of the wards. All these are affected by questions of status and power.

SALIENT ANTECEDENTS OF CONFLICT

Taking my list of immediate antecedents in Table 1, all were observable. Not only were they observable, but often combined in a single instance. It is not just a problem of listing all the possible antecedents, but of pinpointing those with the greatest impact. Those which were noticeable continuously and thus were the most salient were four in number: organizational ambiguity, the organizational-clinical dilemma, orientation differences, and difficulties arising from differentiation.

Although they are listed and discussed separately they are strongly interrelated, illustrating the high degree of the multi-determination of these conflicts within the Hospital.

1. ORGANIZATIONAL AMBIGUITY

The primary task of the Hospital is the care and the treatment of the patient. This task is differentiated. The BBH is organizationally divided into a managing system and various operational units. The operational units are the various wards on the one hand and the specialist diagnostic and treatment departments such as the OTS, pharmacy, physiotherapy and so on, on the other.

The general managing system and its role is shared between several individuals in charge of their respective divisions. They are the Chief Executive Officer, the Medical Superintendent, the Deputy Chief Executive Officer and the Director of Nursing. The system also includes the service and control units such as Engineering, Domestic, Catering and General Administration.

There is very little conflict in relation to the service and control units. The conflict arises from the fact that the work of the operational units is not being coherently managed. The managing system is more like a complex political arena. It is difficult to determine where the responsibilities of the Executive actually lie in the system. In addition to their general managerial roles the members are also acting in a service and control function. For instance the Director of Nursing gets involved in budgeting and staff allocation. Although it might appear that these are general management functions, and would be so if the operation was a nursing home, they become specialist service and control functions within the management of the Hospital as it is.

The primary task is being effected in the various operational units which are left to be mainly managed by the charge nurses of the wards and the department heads of the specialist departments. Although the charge nurse is responsible for managing certain aspects, there is no individual or group fully responsible for all the activities of the ward. For example, the charge nurse does not control the appearance or activities of the medical staff or the paramedical personnel. This state of affairs has inevitably brought into the open the invitation to conflict.

A typical example is the ongoing clash between area coordinators and the charge nurses. The former feel that because of their authority they should be in charge even though they may lack the clinical expertise. The charge nurses, on the other hand, have no respect for the administration whom they regard as being completely out of touch with the culture of the wards. They see themselves in authority because of their clinical knowledge and experience. The area coordinators are not in fact a higher clinical authority, with a wider span of responsibility than the charges nurses have. They represent a narrower specialization exerting control over some aspects of the charge nurses work. Usually it ends up after a while with some form of collaborating

where things are resolved. Very often disagreement remains leaving bitter resentment or friction.

2. THE ORGANIZATIONAL-CLINICAL DILEMMA

This is a specific instance of a task dilemma. The hospital is inevitably faced with a need to balance the requirements of the treatment of individual patients and the requirements of maintaining the state of the hospital. The dilemma might be felt and faced by individuals - as a general practitioner is concerned with both his patients and his practice. In the BBH this dilemma takes the form of intergroup conflict.

The visiting medical staff do not think organizationally, as I have stressed throughout the thesis. That is, most of the powerful doctors in the Hospital do not take part in the managing of the institution with the people who are trying to manage it. The difficulty is partly due to the nature of the contract between the visiting medical staff and the Board.

The OTS is a typical case in point with the ongoing battles between the supervisor and the surgeons. These doctors are outsiders who are not acting like managers and yet still expect their requirement for clinical practice to be met.

Apart from this example there are many other situations where organizational and clinical objectives clash.

Although the Board is the Hospital's ultimate source of authority, the preeminent visiting medical staff play the major role in clinical decisions and resource allocation because of their medical expertise and dominant personalities. The evidence clearly indicates that the decision-making process for the day-to-day running of the BBH is contained within a power relation between the Administration, the Medical Staff Group and to some extent Nursing Administration. Each party interacting with

another appears to reflect a classic "we/they" dichotomy.

Frequently, border clashes break out between the three specialist parties whereby each tries to protect or enhance what they perceive as their separate decision making territory. The clash between the Chief Executive Officer and the medical staff usually centres on the management of hospital resources for which the former is accountable and which are necessarily depleted by the practitioners in the interests of their patients. The Chief Executive Officer expects the Hospital to be managed efficiently and economically. The visiting medical staff, on the other hand, show no interest in financial matters nor care very much about resource allocation.

Up until recently, if there was a disagreement between the two main parties it was usually settled with the Chief Executive Officer accommodating the doctors' requirements or simply to avoid the issue and for the sake of temporary peace, delay the inevitable. However, what is now becoming clear, is that the government is beginning to impinge on this medical power by seeking to control more effectively the expenditure generated by the medical staff. The Chief Executive Officer finds that he has no option but to try and exert more of his expert power relating to financial and administrative matters in the Hospital. While the medical staff attempt to maintain or increase their power, the Chief Executive Officer is aiming to improve his own status and authority. Problems such as this tend to point out the continual conflict between bureaucratic control and professional autonomy of the behaviour of some of the numbers of the BBH staff.

The effect of all this is that some of the practitioners, especially the surgeons, feel threatened and offended by being dictated to by a non-medical person. Some of them are in fact quite willing and able to circumvent the established committee system and either go directly to the Chief Executive Officer or bypass him and try and seek satisfaction through the Board.

The relations between administration and the doctors are strained at times. Although the doctors seem to be fairly well satisfied with their department's facilities, nevertheless a fairly high degree of mistrust continues to exist between the two parties.

Another continuing conflict over a task dilemma facing the BBH is the question of money versus service. The type and extent of financial support in subsidies or grants affects the operative goal of the Hospital. The lack of resources in the institution are quite obvious, such as the shortage of qualified nursing staff, senior administrative personnel, and the need for more facilities and equipment. The conflict of values and goals lies in the primary task of looking after the sick but within the financial constraints imposed by government funding. All the administration is doing is trying to strike a balance or compromise between the two requirements.

The Hospital is becoming increasingly aware of the need to tighten its purse strings and yet at the same time provide adequate patient care through effective utilization of limited resources. It involves ongoing negotiation and searching by the Chief Executive Officer and the Board for a relatively adequate solution to the dilemma. This also sometimes creates an inter-organizational conflict whereby the BBH and the government try and reach some form of compromise so that both parties are satisfied with the outcome.

3. ORIENTATION DIFFERENCES

Another major cause of conflict which emerges from the field work is the differences in orientation towards the handling of the therapeutic process and the differences between orientation to technical efficiency and to humane patient service. In both cases cleavages appear causing clashes between individuals and groups.

One example of the difference in regard to the therapeutic process is the clash at times between the nursing staff and the mothers in the Children's Ward over the handling of the child. Another example is the ongoing skirmishes between the doctors and the midwives in the Maternity Wing over the handling of the birthing process. The differing attitudes on both sides are quite distinct, often causing a bitter rift between the two parties. It is a clash involving differences in ideology, clinical training and power plays as well as the question of gender creeping in.

Linked to the difference in orientation towards the handling of the therapeutic process is also the question of technical efficiency and humane patient service. It is a question of maintaining adequate primacy of instrumental functions versus meeting the latent demands of the patient for emotional support and psychic gratification. Of course, these two sets of interests, one related to the staff and the other to the patient, sometimes overlap. The requirements of the major divisions of the Hospital impose on the patients demands which are in direct conflict with their total health and well-being.

The tension is evident in the wards and the Delivery Suite where we are dealing with the "processing" of human beings who possess the ability to manage their own affairs. Yet, the patients are often the battleground of professional zeal and competition, and are scarred by attempts to do for them what each staff member's speciality prescribes, thereby leaving the patient insulted, annoyed and frustrated. Life in the wards reflects the need to treat patients and to socialize them into these roles and attitudes which will point the BBH to achieve its main task, namely the application of medical technology in the curing process.

The process of integrating the dual orientations of cure and care are functionally related to the kind of therapy given and the culture in the wards - the status of the practitioner in charge,

the influence of the charge nurse, and the extent to which the patient has the freedom, the ability and the willingness to contribute to his or her own management.

Managing a patient is managing the career of that patient through the Hospital by bringing in varying degrees of intervention and support as necessary. In George's case in the surgical ward, the Hospital and the staff took over his role; with Judy in the maternity wing, it was she to a large extent was given the freedom to manage or control her own affairs.

A number of the following cases in my research are taken as examples to illustrate quite clearly the different goals and orientations by the various professionals in the service: the surgeon, who is medically oriented and aims to cure the patient through the process of diagnosis and treatment working together with a nurse, who is there to carry out the ministering function which concerns the commitment to meet the physical, emotional and psychological needs of the patient; the resident who wants to become a specialist and is just passing through the ward on the way to achieving his career ambition; the midwife who is concerned that under the right circumstances a normal delivery should take place and the gynaecologist, on the other hand, who is more interested in abnormal cases and the necessity for technical intervention; the social worker who is alarmed at the social and psychological traumas facing her patient confronts an administrator who seems oblivious to the needs and is only interested in the financial implications of it all; and the surgeon who schedules his operations above the agreed limit or orders expensive surgical supplies irrespective of the costs incurred or the work pressure forced on other staff members.

4. DIFFERENTIATION

The final major source of conflict in the BBH concerns the issue of the boundaries of specialized functions, which is also at times a struggle for recognition and power. Conflict arises because there are organizational alternatives over the management of the patient or the question as to who is responsible for a certain activity. Because there are overlaps in the treatment and care of the patient, battles rage over who has the occupational rights or who can decide on a treatment.

Each party has its own unique frame of reference, perceiving itself as holding its own decision-making rights. The territory is then strongly defended if anyone else tries to encroach on it. It is the result of incompatible expectations among the staff about their relative influence and status, their desire to protect valued roles and to maintain a sense of autonomy. Often it becomes a power struggle where each party tries to compete or stand up for their rights in order to protect their self image.

The majority of intergroup conflict within the BBH occurs between the medical staff and other health care personnel such as the nursing staff, physiotherapy and social workers. Most of these skirmishes centre around the senior nursing staff from administration as well as those from the wards and the Operating Theatre Suite. Doctors regard all of these other occupations as of much lower status in any decision making process that relates to patient care and react quite negatively to any intrusion into that territory. Often negative stereotypes are developed as each party belittles the other's views and ideas. The case study shows quite clearly the growing tension over this issue between the VMS and some of the senior nursing staff from the administration as well as those from the wards and the Operating Theatre Suite. These border disputes are also sometimes reinforced because of personality clashes, frictions between members within each division, dysfunctional communication, unplanned introduction of change, gender issues and tradition.

Many of the tensions between the medical staff and nursing are characterized by medical dominance and devaluation of nurses; the latter's dependence on the doctor who has to be served and satisfied; and the disinterest and lack of understanding that each party shows to the values and tasks of the other. Nevertheless, it is also becoming quite noticeable that more and more nursing staff are seeking to expand their role or zone of authority by becoming more professionalized. They seek to increase their prestige vis-a-vis the medical staff, while at the same time try and fight off encroachments upon their present status by the paramedical staff.

Some doctors are quite reluctant to recognize the increased professionalization, and are sensitive and angry because they see this manoeuvering as an encroachment on their autonomy and an intrusion into patient care management. Others are more receptive to the situation and get on reasonably well with the nursing staff. Many senior nurses, on the other hand, are expressing considerable animosity and resentment towards the doctors. They find some of them patronizing and demeaning and are frustrated because of their nonsupportive attitude towards them.

This situation is quite noticeable in some wards, the Maternity Wing and the Operating Theatre Suite. Some of the nursing administrators at the BBH find themselves in a bind by having to recognize that cooperation with the medical staff is necessary for effective patient care. At the same time, however, they are encouraging their senior staff to be more assertive and confronting when the need arises, especially towards the younger and more inexperienced ones.

Another interesting and similar scenario in the Hospital is the relation between the interns and the charge nurses. Each again perceive their own status as higher and more influential than the other; the former because he occupies a position of authority over the rest of the personnel who work in the ward,

and the Charge Nurse because of her clinical expertise and experience. In reality, the authority boundaries are somewhat fuzzy and complex because they both depend on each other. Nevertheless, sometimes the charge nurse forgets where she leaves off as a nurse and finds, because of her continuous advice giving, she is acting more like a doctor. If the conflict between the two parties becomes a critical issue as far as the patient is concerned, then the practitioner is called in to solve the issue.

DOCTORS AND NURSES

Something should be said about the role of the doctors and the nurses which emerge from the analysis. It is quite clear that the medical staff are the key players and power brokers in all of these four salient antecedents of conflict. The part-time nature of their engagement is linked with their part in the incoherence of the managing system and in the acting out of the organizational-clinical dilemma. This is not so much the case in the UK, where hospital doctors are not so cosmopolitan because many are wholly or substantially full-time and play a much bigger part in the general management of the hospitals.

At the BBH, the medical staff are continuously encouraged to become more involved in the leadership and administration of their institution even though they are part-time. Although most of them claim that they have absolutely no time to get administratively involved, it really depends not only on their perception of their proper professional role, but also on the perception of other professions as well. In this respect, the doctors are involved in the isssue of differentiation of function on a clinical basis as well as on the issue of power relations with other groups in the Hospital. The wider issues of the changes in gender relations in society generally also add to the conflict, often quite explosively.

Apart from these issues there is also the question of differences in orientation to the primary clinical task. This would always be present even if doctors individually or as members of their profession took a full part in management. It would also be present if their power relation with nurses were stable and reciprocally accepted.

What is characteristic of the BBH is that the doctors' role in the four salient antecedents of conflict get compounded together. Whilst it is possible notionally and logically to distinguish between them, in reality they are quite inseparable. Effectively 'managing' any one of the antecedents would involve a decoupling in action rather than in ideas.

The nurses are also involved to some extent in all four salient antecedents, but are more caught up in them and are not so much the initiators. The wider issues of gender relations, the changes in the content of the clinical work, and the increasingly complex demands of institutional management are pushing the nursing staff increasingly towards the position of the doctors. The underlying tensions between the two professions continues to fester, and are not likely to decrease. The nurses who have lost power generally in hospitals in the US, UK and Australia will try to hold on to what they have left, or try to increase their power base not only through becoming more clearly professional, but also through industrial action. Becoming industrialized and exerting collective power is less productive for patients than becoming increasingly professional and sharing power with the doctors and other professionals.

There are many possibilities which are not fully realized of more effective involvement of doctors and of nurses in the general management of the Hospital. As to the question of conflict, it is very difficult to envisage any resolution which depends on reverting to a model which probably never existed anyway: the doctor as the patriarch with the power, skill and knowledge, who sweeps in, performs and receives deference and acclaim (some still do); and the necessary concomitant, the nurse as handmaiden, who defers, obeys and serves.

FINALLY

Conflict in the BBH is endemic and multi-determined. Each issue or expressed conflict carries several determinants at the same time. When a conflict starts between certain individuals in the Hospital it usually broadens and is taken up as a group fight. Each party takes sides over the dilemma they are facing. The more sources, or what I call contextual factors and immediate organizational antecedents, are involved, the more intractable the situation becomes. This in turn causes members of each group to dig their heels in, causing a solution to the conflict to drift away even further.

The BBH is not a smoothly running machine where people interact in harmony. What I have found is that people find themselves caught up in the structure of which they are part. They do not manage the conflict that they face, as they do not find some way of taking collective responsibility in order to move the conflict toward a constructive resolution in those cases where resolution is possible.

It was quite noticeable that in cases of a threat to their position, like the situation in the Operating Theatre Suite, the surgeons closed ranks, even though there is friction between them, put aside their former disagreements and simply refused to accept any change or reflect accurately about their respective positions. It may well be that this state of affairs suits them, as they have little desire to lose their traditional autonomy and control.

In addition, what any member of staff seeking changes is able to accomplish will be circumscribed by the features of the culture in which they operate. People who choose to challenge the status quo run into difficulties and have to pay the price of facing the conflict they produce. The other choice is to let things pass,

and the price of that is failure to deal with introducing the changes which are necessary in coping with the environment.

My enthusiasm for finding aids to managing conflicts more effectively was dissipated. Even though all those methods mentioned in Chapter 3 were known to me, this knowledge was superflous. I had seen myself as the quasi-physician and it was obvious as well as unfortunate that no matter how knowledgeable I was there was no magic potion to make the patient healthier. People were "too busy with patients", too concerned with their own problems and sceptical of "text book stuff" and of an outsider coming in to offer solutions.

People are continuing to operate on their tasks in the presence of conflict around them. I found that people blamed others instead of themselves, or simply walked away from it all, continuing to live with the ongoing battles and skirmishes.

I became aware that much of the literature offering rational means of conflict management are of little use in complex organizations like this Hospital, where conflict is multi-determined, linked at different levels, and locked in place by the influence of wider contextual factors. For instance, what may be needed is a structural solution, which would become possible only through finding a solution to or a de-coupling from the wider professional issues.

Very often it was the dominance of the task that blinded individuals to thinking organizationally. Nevertheless, the power of the patient's need forced people to put conflicts aside, thereby making the situation tolerable. It was evident that there were forces at work which served to pull together individuals and groups for the sake of the primary task. It is the nearest that the people in the BBH get to managing their conflicts. There is a paradox here. One the one hand the staff are trying to achieve a super-ordinate goal of caring for and treating patients, which

looks like a sophisticated means of conflict resolution. On the other hand, in the process of treating the patients, they deny its presence and power.

The ideology of commitment and service coupled with the presence of the patient and his or her needs tends to unify to some degree the various parties in the hospital. This service orientation is part and parcel of many occupations in the Hospital helping them at times to transcend their self-interests and work together for "what's best for the patient".

APPENDIX 1.

REPORT

TO

THE OPERATING THEATRE SUITE INTERIM COMMITTEE

I. THE SITUATION (As I see it)

(A) THE IMPORTANCE OF THE OPERATING THEATRE SUITE

There is no doubt that the Operating Theatre Suite plays a major role towards the attainment of the Hospital's major objective, namely patient care and treatment. It is one of the most important and expensive units within the institution. Perhaps in no other area of the Hospital is there such a concentration and diversity of skilled personnel performing procedures which require teamwork, co-operation and the best of organizational backup.

In the O.T.S. no one can "go it alone"; each person is dependent on various others, and the patient, who is the centre of attention, is, of course, dependent on all members of the team. Apart from teamwork and co-operation, great stress must be placed on efficiency and expertness. But it is more than that. It is the extent to which people trust, support, respect and feel comfortable with one another. This is what influences the effectiveness of the O.T.S.

Unfortunately, it seems that this unique community is in conflict. The community goal and the teamwork has gone; everyone is paddling their own canoe. There is a feeling of discontent, tension and hopelessness among the Theatre Staff and the Visiting Medical Officers. The O.T.S. is under considerable strain coupled with a steady wastage of experienced nursing staff and there are signs that all this may be affecting the quality of patient care.

(B) PRESSURES AND PROBLEMS

As far as I can perceive (having interviewed various members of the O.T.S. and key personnel in other areas of the Hospital), the following major problems can be identified:

(1) Uniqueness of the Hospital as an Organisation (including the O.T.S.)

- continuous operation of crucial anxiety-provoking personalized service.
- high degree of specialization and differentiation making co-ordination difficult.
- many interfaces between three major lines of authority (medical, administration, and nursing).
- authority, autonomy and prestige of the "visiting" medical staff; control of the therapeutic process; individual power brokers responsible only to the Board.

(2) Lack of Resources

- funding provided on a historical staff profile basis; shortage of qualified nursing staff; lack of equipment and careful monitoring of supplies.

(3) Tradition (and Personalities)

- establishment of own unique culture of the O.T.S. over many years.
- strong power and autonomy of the Medical Staff.
- previous Supervisor (matriarchical, respected, democratic leader, skilled communicator; conflict management through compromise, also saw need for change).
- harmonious atmosphere; co-operation.
- old habits hard to break; "good old days".

(4) Diversity of Personnel

- O.T.S. is a small community with high degree of professionalization and specialization.
- different orientations, training, education, values and attitudes; class of sub-cultures, self-interest.

(5) Factions

- skirmishes between the Medical Division and the Nursing Division (Key representatives).
- frictions between members of the Medical Staff.
- factional infighting amongst the Nursing Staff (old guard v. newcomers).
- split in the anaesthetic camp (A team v. B team), etc.
- squabbles between Technicians and Nursing.

(6) The Supervisor

- perceived problems in communication with various groups within O.T.S.
- interest of patient and greater efficiency all round.
- new to the O.T.S. (not from Bendigo).
- support from the Director of Nursing.

(7) Communication Breakdown

- few Nursing Staff meetings; decisions made not passed on.
- change of Theatre in the last minute and staff only then informed.
- lack of interest by Medical Staff to discuss problems with Director of Nursing.
- Nursing Administration information not being passed on by Medical Staff.
- lack of knowledge by Nursing Administration as to detailed happenings in the O.T.S.

(8) O.T.S. Committee

- inefficient; no major decisions made; if decisions made, they are not passed on to the Medical Staff and the Nursing Staff.
- clash of dominant personalities.
- trench warfare between nursing and medical factions.
- issues rushed through with no proper consultation.

(9) Lists, Attire, Equipment and Supplies

- operations scheduled above the agreed limit.
- booking in certain procedure and change in the last minute.
- bookings at own convenience to Medical Staff without prior consultation with Supervisor or Charge Nurse.
- Nurses under pressure with no proper meal breaks.
- Supervisor wishing to achieve greater throughput and proper work schedules for Nursing Staff.
- Supervisor accused of inflexibility.
- squabbles over Theatre attire and infection control principles.
- question over necessity of new equipment purchase; lying around idle.
- equipment bought by one member of the Medical Staff and not used by others in the same specialty.
- purchase of expensive medical and surgical supplies.

10. Introducing Change

- all major problems in O.T.S. revolve around change (new personalities, new ideas about procedure).
- contention centring on two key issues
    - change for the sake of change
    - way in which change is being introduced.
- Supervisor's genuine belief in the need for change; improvement; greater efficiency; gaining accreditation.
- no discussion, no consultation, no encouragement of input.
- change made even though procedure was running smoothly; no value.
- change introduced and then later back to status quo again.
- people not willing to accept change because of vested interest, fear of unknown, comfort of the familiar, threat to power, threat to economic loss.
- to accept change people must be involved and understand its merit.
- dealing with the resistance of change requires an understanding of the culture of the system, communication skills, democratic leadership and diplomacy.

II. SOME SUGGESTIONS FOR IMPROVING THE SITUATION IN THE O.T.S.

(A) KEY FACTORS INFLUENCING EFFECTIVENESS

The O.T.S. is a unit or small community with its own culture and diversity of professional personnel trying to achieve a given task. The task is to provide the special controlled environment necessary for the performance of surgery in the investigation or treatment of illness or injury.

There exists a unique connection between that task and how the O.T.S. goes about doing it, namely its internal group process. The accomplishment of the task requires the interdependent and collaborative efforts of its members. That is, the O.T.S. itself must, in many ways, operate as a highly integrated and well-tuned machine. Without this, ability to maintain itself may cause a slow disintegration of the unit.

Members of the O.T.S. must be helped to see the connection between what they are doing (the task) and reflect on how they are going about it (the internal group process). If the O.T.S. is to function as a team it must know what is its task, which means identifying and defining what is required of it. That is, members must have a shared, agreed-upon common definition of the O.T.S.'s mission. In addition, goal priority conflicts must be understood and be clearly resolved. This avoids members working at cross purposes.

Having established a common task, it is now a question of reflection on the internal process which relates to interdependence and collaboration. The O.T.S. personnel must accept that no one on the team can do this without the others. There may be disputes as to who has authority over what, but overall there must be an understanding of the interdependence of the staff and that each has something to offer in expertise, experience, and maturity. In fact disagreement is essential if something constructive, innovative and beneficial is to emerge. It is the manner in which conflict is managed that is vital.

To understand how the O.T.S. is going about its work can be analysed by focusing on the following key variables which affect the functioning of the unit:- goal issues; decision-making; role expectations; communication patterns; leadership; concern for each other's needs.

1. Goal Issues

In the O.T.S. there will be issues like:-

1. How clearly defined are the goals?
2. Who sets the goals?
3. How much agreement is there among members concerning the goals? How much commitment?
4. How do the O.T.S. goals relate to broader hospital goals? To personal goals?

Since the O.T.S.'s very existence is to achieve its mission, these issues are of central importance.

2. Decision-Making

(i) The O.T.S. is a decision-making mechanism with the issue being one of relevance and appropriateness.

Who has the relative information?
How is information shared?
How are decisions made?
- by default (lack of group resource)
- unilateral decision (authority rule)
- majority vote
* - consensus

Each form is appropriate under certain conditions.

(ii) How is conflict resolved?

- ignored, smoothed over; allow one person to force a decision; create a compromise; or confront all the realities of the conflict (facts x feelings) and attempt to develop an innovative solution.

The choices that are made in both of these areas will significantly influence the function of the O.T.S.

3. Role Expectations

In developing a cohesive effective team, each staff member must be aware of the nature and extent of each other's role so that there are no false expectations and misunderstandings. Each person, in effect, has a set of expectations of how each of the other members should behave as the O.T.S. works to achieve its task. Questions should be asked about:-

1. The extent to which such expectations are clearly defined and communicated, i.e. are people clear about what they expect of one another? (role ambiguity)

2. The extent to which such expectations are compatible or in conflict (role conflict) (e.g. the Surgeon, the Supervisor, the Scout Nurse and the Incumbent may all have different expectation about the role of the Scrub Nurse).

3. The extent to which individuals are capable of meeting these multiple expectations (role overload).

4. Communication Patterns and Leadership

Both the effective flow of information and multiple leadership are conducive and central to the proper functioning of the O.T.S. It is important to establish how decisions are forwarded on to the appropriate parties concerned, both administratively and verbally. The following questions could be asked:-

1. What is the communication flow and under what circumstances does it occur? - downwards, upwards, horizontally.

2. What meetings are held that affect the functioning of the O.T.S.? Are these meetings effective; if not, why not?

3. Should the O.T.S. Committee be revamped in any way?

Related to the process of decision-making and communication is the aspect of leadership. Depending on the situation and the problems to be solved, different people can and should assume leadership. Is there a multiple leadership in the O.T.S. as a whole and what style of leadership is apparent within the various groups?

5. Concern for Each Other's Needs

If the O.T.S. is to become a cohesive group each staff member must show concern for the others as human beings as well as in their professional role. Questions could be asked about:-

- Is it possible to express views and feelings on a topic?
- Disagreeing with others about their views?
- Is there respect for other's ideas and opinions?
- Are ideas dismissed without due consideration?
- Are people sensitive to personal problems?

Only under these circumstances will consensus be encouraged and team members will strive to do their best.

If the O.T.S. is to function more efficiently it must develop the capacity to review itself as a team. It can do this first by becoming aware of how its internal group processes influence its ability to function and, second, by learning how to manage these processes or maintenance needs in a more productive manner.

(B) ACTION PLANNING

Data Collection) → Summarization and Feedback) → Action Planning) → Evaluation

In order to help the O.T.S. improve its functioning I suggest that we use an action research approach reflected in the basic flow of activities as depicted above. Before the data is collected, however, it is important that everyone concerned is given a briefing of the problem in question and the evidence relating to it. I have already tried to provide this in the summary of the situation as I see it.

Data Collection

This initial activity involves the gathering of information relating to the questions from the list of the five process factors discussed earlier. Members from the various professional groups and sub-groups connected with the O.T.S. should lend their support by answering these questions either verbally by interview or in writing.

Summarization and Feedback

This data should then be summarized and fed back to the Interim Committee, keeping names of respondents, perhaps, anonymous. The summarization may be carried out either in total, representing the views of all the various participants combined, or depicting the views of each separate professional group.

An individual or a selected few must then be given the task to collect and summarize the information accordingly. The collection of ideas and unbiased data about the problem and its interpretation is a critical phase in the whole action planning process.

This valid source of information (feelings and facts) will provide an image or picture of the present situation. The fact that staff have become involved and have shared in the process of collecting this data, may hopefully heighten their commitment to solve their problems.

Action Planning

In order to cope with the various complex problems facing the O.T.S. it is important for the Interim Committee to firstly prioritize the major issues reflected in the summarization of the data. Once this has been accomplished, the Committee must decide upon the most appropriate solution alternatives. This involves developing a clear and shared set of objectives indicating what the improved state should be.

Those staff that are involved in providing the data should, perhaps, also be involved in producing ways of solving the problem, discovering what are the options, and which options are better than others.

Evaluation

Once a solution has been found and implemented, specific mechanisms and procedures must be found for checking the progress, i.e. a reassessment of the situation to determine whether the situation has improved or changed in any way.

I sincerely hope that O.T.S. staff members can be helped to see the connection between what they are doing (their task) and how they are going about it (their internal group process). This expanded awareness can help in the development of new ideas and attitudes towards better co-operation and an overall team effort.

JOHN A. PACHER,
11th February, 1988.

APPENDIX 2.

DISCUSSION PAPER RELATING TO PROPOSALS FOR IMPROVING WORKING

RELATIONSHIPS WITHIN THE OPERATING ROOM COMPLEX

The following paper is prepared based on feedback received from interviews with Operating Room staff conducted by the Interim Theatre Committee Registered Nurse representative, comments received from members of the Interim Theatre Committee, the report presented to the Interim Theatre Committee by Mr John Pacher and information and comments received from past interviews and discussions with staff.

Whilst poor interpersonal relationships and personality traits and work performance in a variety of areas are recognised as being major contributory factors to the problems facing the Theatre complex and issues that must and will be dealt with individually, this paper has been concentrated on problems relating to organisational structure and lines of authority; utilization of staff expertise and knowledge, lines of communication and the need to develop a management structure which will foster a cohesive team approach within the Operating Suite, provide greater job satisfaction and opportunities for staff development and involvement in the decision-making process.

The paper is by no means exhaustive but is intended to provide a starting point for addressing some of the more tangible problems.

ORGANIZATIONAL STRUCTURE

From the discussions with medical staff at the Interim Theatre Committee meetings and feedback on staff comments, it is quite evident that lines of delegated authority are unclear and at times overlapping. This creates confusion and frustration and impedes the efficient running of the Operating Suite as staff are unsure as to whom they are directly responsible.

Various staff have expressed perceptions of lack of recognition as members of the Theatre team and lack of opportunity to fully utilise particular skills or knowledge creating lack of job satisfaction. Medical staff have also expressed the desirability of having staff experienced and interested in specialty areas to assist with elective cases and the need to have one Registered Nurse within each Theatre responsible for the co-ordination of activities within that Theatre.

Given that the Operating Room Complex caters for a wide range of elective and emergency surgical procedures, over a 24 hour period and also that the educational needs of student nurses must be met, it is essential that all Registered Nurses are versatile and well practised in all aspects of Operating Room nursing. So too the variable demands on nursing staff resources unfortunately does not permit the luxury of having specific staff constantly allocated to specific specialties.

However it is important that these issues be addressed as far as it is possible to do so. It is therefore proposed that consideration be given to adopting a team approach to the organizational structure and management of the Operating Room Complex. To this end a possible model which may achieve this is set out in the following attachments and are presented for consideration and discussion by Theatre staff.

It is recognised that the proposed structure is a departure from the established organisation and obviously may require some modification. However it is felt, given the comments received, a genuine effort must be made to overcome the problems identified and the model proposed would appear to be a feasible way of addressing the issues.

SUGGESTED RESPONSIBILITIES OF OPERATING ROOM STAFF TO PROVIDE GREATER JOB SATISFACTION AND PROMOTE TEAM CONCEPT

1. AREA CO-ORDINATOR - OPERATING ROOM COMPLEX/T.S.U.

- Overall co-ordination of Operating Room/T.S.U. activities and associated administrative and organizational responsibilities.

- Receipt and approval of elective Theatre lists in consultation with the Admissions Clerk.

- Receipt and organizing of emergency cases or semi-urgent additions to Operating lists in consultation with Medical staff and giving consideration to urgency of cases and resources required.

- Forward planning of resource needs and financial management of Theatre budget.

- Researching Theatre utilization and monitoring efficiency of sessions allocated.

- Liaison with Medical staff regarding policy or procedural matters, equipment needs, unresolved personnel or administrative matters.

2. CHARGE NURSE

- Responsible for day to day internal activities (daily staff allocations; co-ordination of activities between Theatres; Anaesthetic Rooms and Recovery area; in consultation with Area Co-ordinator and Associate Charge Nurse/Team Leader; reallocation of staff between Theatres to accommodate emergency cases, heavy workloads or staff sickness or absences; communicating to the Associate Charge Nurses/Team Leaders any matters specific to each Theatre allocated.

- Communication of changes occuring during the day to appropriate Associate Charge Nurses and/or other staff members and documentation of changes to operating lists or case times.

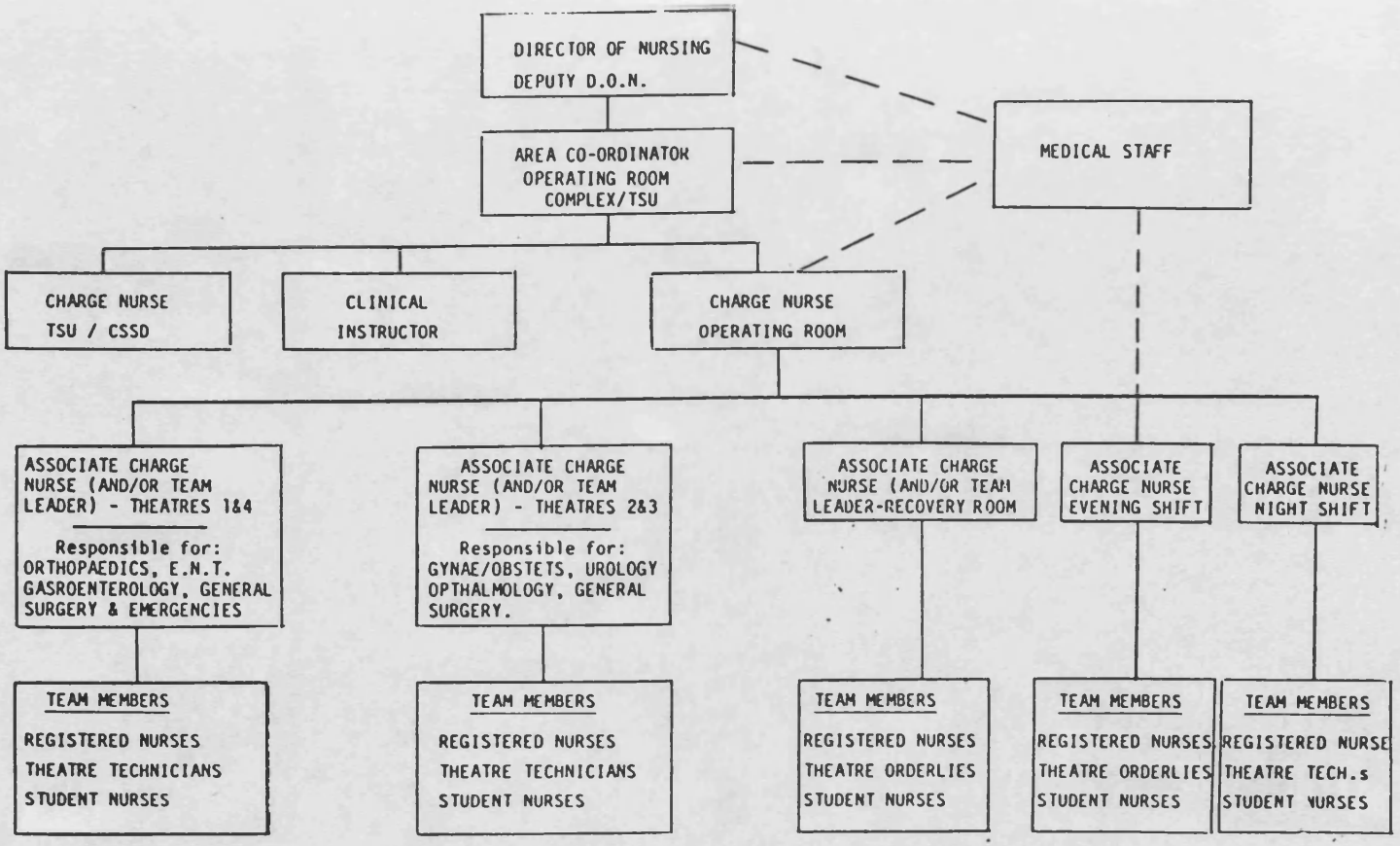
- In liaison with the Associate Charge Nurses/Team Leaders, arrange for transfer of patients to the Theatre Suite.

- Liaison with medical staff regards special needs, problems or difficulties relating to specific cases undertaken during the day and where necessary or appropriate, referring such matters to the Area Co-ordinator.

- Communication with oncoming Associate Charge Nurses (and/or Team Leaders) re current Theatre activity.

- Administrative tasks delegated by Area Co-ordinator such as fortnightly rostering of staff, ordering a maintenance of supplies and equipment.

- In absence of Area Co-ordinator receipt and organisation of emergency cases or semi-urgent additions to Operating lists.



SUGGESTED POSSIBLE ORGANIZATIONAL STRUCTURE
FOR OPERATING ROOM COMPLEX

3. ASSOCIATE CHARGE NURSES (AND/OR TEAM LEADERS)

- Organization and co-ordination of all team members within allocated Theatres or Recovery Room, (i.e. Registered Nurses, Theatre Technicians and Orderlies, Student Nurses, State Enrolled Nurses).

- Communication with Charge Nurse (or after hours with Nursing Administration regarding staffing needs or need for special equipment or supplies, or problems arising within allocated Theatres or Recovery Room Area.

- Notification of Charge Nurse regards readiness for next case or delays occurring between cases.

- Liaison with surgeons, anaesthetists, procedurealists within the Theatres allocated regarding matters directly related to cases being undertaken (e.g. special equipment required, problems encountered during as case). As necessary referring these matters to the Charge Nurse or Area Co-ordinator.

- After hours arrange transfer of patients to and from Operating Suite.

SUGGESTIONS FOR PROVIDING IMPROVED RECOGNITION AND GREATER UTILIZATION OF STAFF EXPERTISE AND KNOWLEDGE

Whenever possible and giving consideration to the total staffing resources available, the need for all Theatre staff to maintain general Theatre skills and the educational needs of student nurses; staff with specific interests or expertise should be allocated to assist Specialist Surgeons with elective lists. Such staff including Theatre Technicians, should also be involved in planning of resources or facilities needed or proposed changes specific to their area of interest or special expertise.

Staff should also be encouraged to take up or seek out opportunities for upgrading and maintaining their specialists skills through attendance at study days and seminars, visits to other institutions and undertaking further post-basic studies specific to their area of special interest.

Further recognition of their specific skills and knowledge could be afforded through their involvement in providing short clinical tutorials as part of the Operating Room Complex Inservice Education Programme.

Staff with specialist skills or interests, if not members of the Theatre Procedure Committee, should be encouraged to present opinions and ideas to and/or attend Procedure Committee meetings.

It must however be recognised that longevity of service alone does not constitute total expertise. In fact all staff must be able to demonstrate a sound knowledge of current standards and practices and present informed opinion based on up to date knowledge acquired from reference material, recent attendance at educational sessions, information received from other institutions and professional organizations, etc.

SUGGESTIONS FOR OPENING UP LINES OF COMMUNICATION WITHIN THE OPERATING ROOM COMPLEX.

One of the major obstructions to communication within the Operating Room Theatre Complex, setting aside personality issues and poor interpersonal relationships skills in a variety of areas, has been the failure of staff to utilise existing established communication mechanisms and reliance upon word of mouth without reference to persons directly responsible or involved in the issues at hand.

It is however also true to say that in some instances established mechanisms have not been well maintained or have failed for a variety of reasons, e.g. failure or inability to keep Theatre lists updated, ad hoc nature of staff and Committee meetings, attitudes to and methods of implementing change.

It is therefore essential that existing communication mechanisms are strengthened in the future and it behoves each and every member of staff to utilize these mechanisms efficiently and effectively.

1. Operating Room Staff Meeting to be held weekly with minutes recorded and available for staff to read and refer to; verbal feedback to be given regarding relevant issues raised at Theatre Committee, Procedure Committee and other hospital meetings.

2. Procedure Committee - to be reconstituted following review of terms of reference and membership. Meetings to be held regularly each fortnight. Further development of the provision of ad hoc attendance of relevant categories of staff at all levels to give input into decision making on issues specific to their area of expertise or responsibility.

3. Notice Boards and Communication Book - information to be kept up to date and all staff, particularly part-time staff, to undertake to read notices and entries regularly, especially on returning to duty following periods of absence.

4. Theatre Lists - suggest number in Operating Suite be reduced with only 2 or 3 lists being posted in key positions. This would reduce time involved in marking changes on all lists and lessen the likelihood of misinformation caused by some lists not being altered.

5. Minutes of Meetings - copies of all Theatre and Hospital meetings to be readily accessible to staff and staff to ensure that these are read.

6. Policy and Procedure Manuals - staff to have access to and utilise Theatre and other Hospital manuals as reference sources.

7. Attendance at Hospital Staff Meetings and informal communication with other staff outside Theatre - it is essential that Theatre staff utilise all opportunities to develop communication links with the broader hospital community of which they are a part.

8. Increased liaison between Nursing Administration and Operating Room staff - the Director of Nursing and Deputy Director of Nursing will from time to time attend staff meetings and make other informal contact.

9. Staff Appraisals - consistent with procedures to be developed within other wards and departments, a self-appraisal system will be developed

Continued

9. to enable staff to review own work performance based on job desciptions and achievements of personal professional objectives.

The suggestions and proposals put forward in this paper are aimed at promoting discussions and constructive suggestions and input is sought and encouraged from all levels of staff.

DIRECTOR OF NURSING

APPENDIX 3.

THE BENDIGO AND NORTHERN DISTRICT BASE HOSPITAL

INTERIM THEATRE COMMITTEE

Minutes of the Inaugural Meeting of the Interim Operating Theatre Committee held on Friday, 29th January, 1988 at 12.30 p.m.

Present: Mr. R. Bakes (Chairman), Mr. J. Pacher, Dr. V. Ratnayeke, Miss J. Edgar, Dr. T. Turner, Dr. T. Evans, Miss M. Cullen, Mr. T. Perera, Mrs. C. Comerford, Mr. W. Ashby.

The Chairman, Mr. Bakes, gave a brief overview of the reason for setting up this Interim Committee stating that continuing poor relationships between many groups of staff in Theatre and inuendo regarding poor work practices and slowing down of throughput had prompted the Committee of Management to establish such a Committee. It was indicated it was thought that the role of the Committee was to clarify and establish clear guidelines for the smooth and harmonious work within the Operating Theatre Complex.

Business:

1. Ongoing Management of Theatre

Dr. Turner raised concern on how the Operating Theatre would continue operating whilst the past Operating Suite Committee was in recess, particularly as there was a view that the Interim Committee was to look at policy matters only. He cited an example of the ongoing problem of pack racks. It was also noted during the discussion with regard to pack racks that the Minutes of the previous meeting held on the 3rd December, 1987 as circulated to members of the Committee did not appear to be accurate or a true record of the proceedings and lacked action clauses. It appeared that the Minutes were not properly recorded or minuted and there was a problem with communication from the Committee.

Miss Edgar / Dr. Turner: That the pack racks be returned to Theatre until further information could be obtained and assessed as to the suitability of pack racks in Theatre.

Miss Cullen / Mrs. Comerford: That the Theatre Committee maintain proper minutes of meetings including information about movers and seconders of motions, whether there was agreement reached on motions, a record be made of the person responsible for taking action, and that the matters discussed within the Committee be communicated to staff.

2. Terms of Reference

Agreed that the Terms of Reference in general covered all matters.

Mr. Pacher / Mrs. Comerford: That the Terms of Reference be changed in emphasis to that as follows:-

1. Consider matters which are thought appropriate.

2. Consider the current communication network and make recommendations as to the appropriateness of same.

3. Review the organizational structure of the Operating Theatre Complex and, if thought appropriate, recommend changes.

4. Review the various operational policies and procedures of the Theatre and, if required, recommend changes. (Various policies to be identified for discussion.)

5. Seek information as to the appropriateness of equipment and instruments currently available in the complex.

3. Reporting

It was noted that reports of the Interim Theatre Committee would be directed to the Committee of Management.

After discussion regarding implementation of recommendations, it was agreed that these should be actioned by the Executive Staff.

4. Tasks for Next Meeting

It was agreed that the highest priority for discussion at the next meeting was:-

(i) The problem of morale and co-operation within the Theatre.

(ii) Consideration of the factors which affect work within the Theatre.

Mrs. Comerford agreed to speak to staff to obtain their feeling about what was happening within Theatre. It was also noted that the Procedures Committee had not met very regularly and this was not assisting with the review procedures. Agreed.

Mr. Pacher indicated that there was a need at the next meeting to investigate the decision making process to ascertain how this was done, that is, on a consensus or majority basis. Mr. Pacher also indicated that there was a need to obtain an understanding regarding the roles of the various persons who worked within the Theatre Complex and how each person in the complex perceived the role of others.

5. Housekeeping

Following discussion it was agreed:

(a) That Miss Cullen and Dr. Turner meet to resolve day to day issues within the Theatre, and

(b) The Procedure Committee meet two-weekly to consider other matters within the Theatre Complex and that Medical Staff be co-opted as required. Agreed that this Committee report via the Director of Nursing to the Patient Care Review Committee.

It was further agreed that the Theatre Committee should not meet any more than once monthly.

Next Meeting: Agreed that the next meeting be held at 12.30 p.m. on the 12th February, 1988.

Suggested that the next meeting after that be held at 12.30 p.m. on 25th February, 1988.

APPENDIX 4.

THE BENDIGO AND NORTHERN DISTRICT BASE HOSPITAL

INTERIM THEATRE COMMITTEE

Minutes of the meeting of the Interim Theatre Committee held on Friday, 12th February, 1988 at 12.30 p.m.

Present: Mr. R. Bakes (Chairman), Mr. J. Pacher, Miss J. Edgar, Mrs. C. Comerford, Miss M. Cullen, Dr. T. Turner, Dr. T. Evans, Dr. P. Crossley, Mr. T. Perera, Mr. W. Ashby.

Apologies: Mr. Pacher, Miss Edgar — That apology for absence be received from Dr. V. Ratnayeke.

Minutes of Previous Meeting:

Mrs. Comerford, Mr. Pacher — That the Minutes of the previous meeting held on Friday, 29th January, 1988 be confirmed as a true and correct record.

Business: (a) Consideration of Report prepared by Mr. J Pacher

It was agreed that the document prepared by Mr. Pacher, which was his perception of what was happening in Theatre following research for a thesis in a doctorate on conflict, be used as a background document.

Dr. Evans made the point that having worked in seven theatres in Australia that all theatres were the same, being difficult environments because of the type of work being done there and difficult with communications.

Mr. Perera also indicated that having worked in operating theatres in Sri Lanka and the United Kingdom he would agree with Dr. Evans comments.

Mr. Perera indicated that with reference to who should be in change, that the Surgeons did not wish to be seen as the "boss" of the complex, however they did believe that they were in charge of matters surrounding the patient during the operation, however it was very much a team effort required to achieve the end result.

There was a case presentation relating to communication problems with relation to one particular patient. Mr. Perera also indicated that he felt that it would be some advantage to have a trained nurse dedicated to each type of case as a general rule, however he was aware of the problems of staff shortages and a training requirement for nursing staff. Miss Edgar generally supported Mr. Perera's comments.

There appeared to be some difficulties in the staff knowing who was actually in charge in the theatre complex in regard to nursing whether it was the Theatre Supervisor or the Charge Nurse. This was causing some conflict. There were instances where meeting news was not filtering back to other persons working in Theatre and there was a need to establish clear lines of communication. There was another instance presented where there were problems with the Ward Clerk booking cases. It was generally agreed that all cases should be booked with the Theatre Supervisor. Dr. Turner indicated this matter had been resolved at a previous meeting of the Theatre Committee and it was agreed that Mr. Ashby send out a memo to members of the Visiting Medical Staff and the Resident Medical Staff asking that they contact "Nurse in Charge of Theatre" to book theatre cases.

The following matters were also resolved:-

Nursing to review the communication chain and the chain of command.

Miss Edgar agreed to discuss and address issues relating to problems between the Theatre Supervisor and the Theatre Charge Nurse.

There was an investigation to be undertaken into session utilization.

Agreed that next meeting be at 12.30 p.m. on Thursday, 25th February, 1988 and the meeting should run to a maximum time of 2.00 p.m.

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